MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5713 Bel Air Rd
Hamilton
02475

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 1511 Shore Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1511 Shore Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Alice M Victor

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel G Victor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 13 1869

8. AGE: Years 77 | Months 10 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Co Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Unknown Fitzpatrick
13. Birthplace: Unknown

MOTHER 14. Maiden name:
15. Birthplace:

16. Informant: Ruth M Keenan
Address: Middle River Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Rd Balto Co Md

16. Funeral director: Wilhelm & Son
Address: 1217 E Fort Ave

19. 3/18/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947 at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 2 1947 to Mch 17 1947
and that I last saw her alive on Mch 16 1947

Immediate cause of death	DURATION
Virus Pneumonia	3d
Due to: Influenza	1 week
Due to:	
Other conditions: Myocardial Disease	Years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. L. Wilhelm M. D. or other
Address: 5713 Bel Air Rd Balto Md Date signed 3/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 02476 P

940

1. PLACE OF DEATH

County Baltimore — Registration Dist. No. 381

Village or City Annesdie — No. 603 Annesdie Rd. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U.S. if of foreign birth? 57 yrs. mos. ds.

2. FULL NAME ANNA EICHER APITZ

(a) Residence: No. 603 Annesdie Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Otto Apitz

6. DATE OF BIRTH (month, day, and year) February 2nd 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	1	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Orsawa (State or country) Austria

FATHER

13. NAME — Eicher

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) Germany (State or country)

17. INFORMANT Mrs. Johanna Wilson (Address) 603 Annesdie Rd. Baltimore

18. BURIAL, CREMATION, OR REMOVAL Place Morelane Mem. Pk. Date 3/17/47, 19

19. UNDERTAKER WM. J. TICKNER & SONS (Address)

20. FILED Mar 17, 1947 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 14th (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 12th, 1947, to March 14th, 1947

I last saw h— alive on March 14th, 1947; death is said to have occurred on the date stated above, at 1:15 A m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary occlusion	Feb 20, 47

Other **Contributory Causes** of importance:

Senility
Arteriosclerosis

Name of operation — Date of —

What test confirmed diagnosis? Clinical symptoms Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) A. S. Chatkoff M. D.

(Address) 5210 York Road Baltimore 12, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

1-25-2-000-10

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

62477

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr. 6 Mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2902 Dunbrin Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George W. Armstrong

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeth M. Armstrong

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 2, 1867

8. AGE: Years 79, Months 10, Days 23. If less than one day ... hrs. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired Lieut. Detective

11. Industry or business: Bureau

FATHER
12. Name: James Armstrong
13. Birthplace: Md.

MOTHER
14. Maiden name: Catherine Burton
15. Birthplace: Md.

16. Informant: Mrs. Elizabeth M. Armstrong
Address: 2902 Dunbrin Rd., Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-28-47 (month) (day) (year)

Cemetery or crematory: xx Mt. Olivet

Location: Baltimore, Md.

18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.

19. 3/27 1947 A. W. Hedrick, D.M. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 1947, at 4.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930, to Mch 25 1947 and that I last saw him alive on Mch 24, 1947

Immediate cause of death: Terminal pneumonia due to asthenia

DURATION

Due to

Due to: Gangrene of rt. foot &

Other conditions: Other Conditions arteriosclerosis; Lymphangitis rt. leg & thigh of 10 days duration
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: E. H. Hayward M. D. or other

Address: 115 E Eager St. Date signed: 3/27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02478

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 23 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Solley
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Glory Beach
(If rural, give LOCATION)

2.(a) If veteran, name war: V.

3.(a) FULL NAME

Emma Bachman (BACHMAN)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Henry Bachman

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 12, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	27	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: August Berkemeier
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Uhde
15. Birthplace: Germany

16. Informant: Hospital records
Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: A. Howard Evans

Address: 1400 S. Charles St. Balto 30 Md.

19. 3/12 (Date received by registrar) 19 47 Asst. Medical Dir. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 19 47 at 11:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Bronchopneumonia	
Due to: Cardio vascular disease	
Other conditions: fracture head humerus ?	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide: accident Date of: March 9-47

Where did injury occur? Catonsville Baltimore (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury: don't know possibly fell out of bed Injured at work? no

23. SIGNATURE: Geo. M. Kieffer M.D. Deceased (M. D. or other)

Address: 1010 Leeds ave Date signed: 3-11-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02479

Reg. Dist. No. 381

1. PLACE OF DEATH:
County: Baltimore
City or town: Sudgus Forge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sudgus Forge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 412 Murdock Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Frances Bacon

3.(b) Social Security Number: 216-16-7072

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Elisha D.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2 1863

8. AGE: Years: 83 | Months: 9 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER
12. Name: Charles Santee
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Anne E Dudley
15. Birthplace: Alexandria Va.

16. Informant: Mrs Adam Geyer
Address: 412 Murdock Rd

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 3/11/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md

18. Funeral director: Wilson & Son
Address: 1214 Eutaw St.

19. 3-10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1947, to March 8 1947
and that I last saw her alive on March 7 1947

Immediate cause of death	DURATION
Senile Debility	
Due to: Heart Failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Alex J Gage M D
Address: 709 N Broadway M. D. or other
Date signed: 3/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

02480

Reg. Diat. No. 441

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:
Vets.Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)

Street No.: See above.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: JOHN A. BAUMGART

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myra Baumgart

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): 1/30/99

8. AGE:

Years	Months	Days	If less than one day
48	1	28	....hrs. ....min.

9. Birthplace: Joppa, Maryland, Harford County
(Town, county, and state)

10. Usual occupation: Protective Operator

11. Industry or business

FATHER
12. Name: Henry Baumgart
13. Birthplace: Joppa, Md.

MOTHER
14. Maiden name: Alice Johnson
15. Birthplace: Joppa, Md.

16. Informant: Clinical Records, Vets.Adm. Hosp.
Address: Fort Howard, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Apr 1, 1947 (month) (day) (year)

Cemetery or crematory: Cokesbury

Location: Abingdon Maryland

18. Funeral director: Howard K. McCormick

Address: Abingdon Maryland

19.....19..... (Date rec'd by registrar) Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 19 47 at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 19 47, to March 28 19 47 and that I last saw him alive on March 28 19 47

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	2 years
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operation: .....Date of op.....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIR.
M.D. Other

Address: VAH. FT. HOWARD, MD. Date signed: 3-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-440-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02481

Reg. Diat. No. 20

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 110 Forest Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 110 Forest Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ELISE S. BLOEDE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Victor G. Bloede
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1861

8. AGE: Years	Months	Days	If less than one day
86	1	18	..... hrs. ..... min.

9. Birthplace: Louisville, Ky. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
12. FATHER Name: Karl Schon
13. FATHER Birthplace: Germany
14. MOTHER Maiden name: Maria Franziska Duringer
15. MOTHER Birthplace: Germany
16. Informant: Mr. Carl S. Bloede, son
Address: 127 Arbutus Ave., Catonsville
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/11/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Crematory
Location: Baltimore, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.
19. 3/11 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 19 47 at 9:30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 23rd 19 47 to March 9th 19 47 and that I last saw h.. alive on March 9th 19 47

Immediate cause of death	DURATION
Pulmonary Edema (Repeated attacks since	Feby 23/47
Due to Pulmonary infarcts since	" "
Due to Arteriosclerotic heart disease signs since 1938	
Other conditions Generalized arteriosclerosis. Hypertension noted in 1937	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Louis P. Hamburger M. D. or other
Address 1207 Eutaw Place Date signed III-10-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02482

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: East Joppa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George T. Blucher

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Agnes Pfeifer Blucher

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February 15th, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	8	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Truck Farmer

11. Industry or business

FATHER — 12. Name: George W. Blucher
13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Amelia Horn
15. Birthplace: Baltimore, Maryland

16. Informant: Mr. Walter W. Blucher
Address: Joppa Rd. Opp. Ridgley Rd.

17. burial (Burial, cremation, or removal. Which?) Date thereof March 26th/47 (month) (day) (year)

Cemetery or crematory: St. Michaels Lutheran

Location: Perry Hall, Maryland

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

19. 3/25/47 (Date rec'd by registrar) 19____ D. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23rd 19 47 at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47 to March 23 19 47 and that I last saw h[illegible] alive on March 23 19 47

Immediate cause of death	DURATION
arteriosclerotic cardiovascular disease	about years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 621 Harford Rd Date signed 3/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

02483

Reg. Dist. No. 450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore Co. Md
City or town Near Blenheim
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Blenheim Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Near Blenheim Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Blenheim Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Raymond C. Bode

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mable M. Bode (nee Ford) 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1897

8. AGE: Years	Months	Days	If less than one day
49	5	16	hrs. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business for self
12. Name of father Paul P. Bode
13. Birthplace of father Baltimore Co. Md.
14. Maiden name of mother Annie M. Miller
15. Birthplace of mother Baltimore Co. Md
16. Informant Mrs. Mable M. Bode
Address Blenheim Rd Balto. Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 7, 1947 (month) (day) (year)
Cemetery or crematory St. John Church Cemetery
Location Long Green Balto. Co. Md.
18. Funeral director Elmer W. Conklin & Son
Address 924 E. Eager St.
19. Mar 5 1947 (Date rec'd by registrar) A. W. Redgrave Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4, 1947, at 5 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 2nd 1946, to Mch 3rd 1947 and that I last saw him alive on Mch 3rd 1947.

Immediate cause of death	DURATION
Carcenoma of Lung	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel of St. Thos Jenifer M.D. or other
Address Towson 4, Md. Date signed 3/5/47

1 Transcript
Band print

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P&C 131a

3289

Reg. Dist. No. 3 b

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 9 months, 15 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 9 moths, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hamden, Falls Road, 3642
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John L. Bowen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: --

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 9, 1883

8. AGE: Years	Months	Days	If less than one day
64	-	26	hrs. min.

9. Birthplace: Des Moines, Iowa
(Town, county, and state)

10. Usual occupation: Hospital work

11. Industry or business: Hospital

FATHER
12. Name: Thomas Bowen
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susanna Constatine
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22/47 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Ellicott City Md

18. Funeral director: Harry H. Wilkes

Address: 410 Edmondson Ave

19. 5-22-1947 (Date rec'd by registrar) Harry H. Wilkes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1947, at 11:18 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 20 1944 to 1947

and that I last saw h...im...alive on 1947

Immediate cause of death	DURATION
Chronic myocarditis	indefinite
Due to: Chronic interstitial nephritis	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 4-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

02484

Reg. Dist. No. 410

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Pt - 19
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6818 Martin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James S. Broome

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife Sue Etta Daybred
Nov 28, 1882 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 28, 1882

8. AGE: Years	Months	Days	If less than one day
64	3	1	hrs. min.

9. Birthplace Columbia, Pa.
(Town, county, and state)
10. Usual occupation Foreman - Ore Dock
11. Industry or business Bethlehem Steel Co.
FATHER 12. Name John C. Broome
13. Birthplace Penna.
MOTHER 14. Maiden name
15. Birthplace
16. Informant Mrs. Sue Etta Broome
Address 6818 Martin Ave., Dundalk.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1947 (month) (day) (year)
Cemetery or crematory Bethel
Location Columbia, Pa.
18. Funeral director Roland L. Fisher
Address 2112 Dundalk Ave.
19. 3/3/47 (Date rec'd by Registrar) 19 J. McLean Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947 at 10 55 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	5 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M Davis M.D.
Dipl. Med. Examiner, Balto Co. (M.D. or other)
Address Dundalk, Md. Date signed 3/2/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02485

Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore - 19
City or town: Sparrows Point,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
1113 H. Street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Sp'a #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Anne Johnston Brownlee.

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

B.(b) Name of husband or wife: David Brownlee.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19. 1858.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
88	3	25.		

9. Birthplace: Glasgow Scotland.
(Town, county, and state)
10. Usual occupation: Housework at home.
11. Industry or business:
FATHER 12. Name: John Collins.
13. Birthplace: Scotland.
MOTHER 14. Maiden name: Anne Johnston.
15. Birthplace: Scotland.
16. Informant: Anne Steel.
Address: Sp'a #1.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17 1947 (month) (day) (year)
Cemetery or crematory: Parkwood Cem
Location: Rural
18. Funeral director: Ellrich Funeral Home
Address: 2008 Orleans St
19. Mar 5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March. 14. 1947, at 8 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1944, to 19; and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral hemorrhage.	2 days.
Due to: Arteriosclerotic.	
Cardio Vascular disease.	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Collins M.D. M. D., or other
Address: Sparrows Point. Md. Date signed 3/14/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 0248 (7) 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore - 19 -
City or town: Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
1315 Beechwood Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore ~~Sparrows Point~~
City or town: ~~Sparrows Point~~ Near Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1315 Beechwood Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Alexandria Bruce

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed.

6.(b) Name of husband or wife: Frances Elizabeth Bruce. 6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July. 26. 1867.

8. AGE: Years: 79 Months: 8 Days: 3. If less than one day: hrs. min.

9. Birthplace: Greene Co. Va. (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business: Farming

FATHER 12. Name: William George Bruce.
13. Birthplace: Gordonsville. Va.

MOTHER 14. Maiden name: Mary Angeline. Cox.
15. Birthplace: Greene County. Va.

16. Informant: Nedra. Brule.
Address: address as # 1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1947 (month) (day) (year)
Cemetery or crematory: Standardsville, Va.
Location: Green County, Va.

18. Funeral director: Roland L. Fuhrer
Address: 2112 Dundalk Ave.

19. 3/31/47 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 19 47, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July. 1945 to Mar. 29 1947.
and that I last saw h~~e~~r alive on Mar. 29 1947.

	DURATION
Immediate cause of death: Hemiplegia	4 days.
Due to: Cerebral embolism	4 days.
Due to: associated with. arteriosclerotic cardio vascular disease.	15 yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Tollin M.D.
6908 North Point Rd.
M. D. or other
Address: Baltimore - 19 - Md. Date signed: 3/29/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02487

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: none
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10 N. Beechwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rudolph E. M. Buchholz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nita E. Draper
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 29, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	26	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: accountant
11. Industry or business
FATHER 12. Name: Heinrich Buchholz
13. Birthplace: Germany
MOTHER 14. Maiden name: Emily Wattenscheidt
15. Birthplace: Germany
16. Informant: Rudolph D. Buchholz
Address: 10 N. Beechwood Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 28, 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Woodlawn
Location: Woodlawn, Md.
18. Funeral director: John O. Mitchell
Address: 1900 Eutaw Place, Baltimore, Md.
19. 4-2- 1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1947, at 4.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1945, to March 26 1947 and that I last saw h.im alive on March 26 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	6 da.
Due to Coronary Sclerosis	2 yr.
Due to	
Other conditions Hemiplegia	2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William K. Gallagher, Md. M. D. or other
Address: 6209 Frederick Ave. Date signed
Dr. Gallagher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02488

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one year
Hospital, institution, or street address where death occurred: Hood's Nursing Home
How long in hospital or institution? one year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: none
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2633 N. Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Carrie Burnett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 16, 1865

8. AGE: Years	Months	Days	If less than one day
81	5	18	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Joseph P. Burnett
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Elizabeth Standiford
15. Birthplace: Md.
16. Informant: Elizabeth F. Kellum
Address: 2633 N. Charles St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/8/47 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: North & Greenmount Aves., Balto., Md.
18. Funeral director: John M. Fetchell & Sons, Inc.
Address: 1900 Eutaw Place, Baltimore, Md.
19. 3-8 (Date rec'd by registrar) 19 47 Harry G. Wilke Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1947 19 ..., at 5P, M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 19 47, to Mar 6 19 47
and that I last saw h... alive on Mar 6 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Cerebral Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 715 Frederick Ave., Catons Date signed: 3/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

02489

Reg. Dist. No. 381

1. PLACE OF DEATH:
County: Balto
City or town: Ridenwood (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Balto
City or town: Ridenwood (If outside city or town limits, write RURAL and give nearest town)
Street No. Roldeaye Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George H. Byers
3.(b) Social Security Number 219-01-7056

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Sallie Byers
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): June 1 1863
8. AGE: Years 83 Months 8 Days 7 If less than one day ... hrs. ... min.
9. Birthplace: Carroll Co. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: Frederick H. Byers
13. Birthplace: Carroll Co.
MOTHER 14. Maiden name: Susan Feezer
15. Birthplace: Carroll Co.
16. Informant: Leighton O. Byers
Address: Ridenwood Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 11-47 (month) (day) (year)
Cemetery or crematory: Krider's Cemetery
Location: Carroll Co.
18. Funeral director: H Bankard & Son
Address: Westminster Md.
19. March 9 1947 (Date rec'd by registrar) [signature] Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947, at 6:20 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (for about 5 years) 1941 to March 8 1947 and that I last saw him alive on March 8 1947
Immediate cause of death: Heart failure

	DURATION
Due to: Arteriosclerosis - Mitral insuf. & Stenosis	
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings at operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [signature] M.D. (M. D. or other)
Address: 2301 Poulan Place Date signed: March 8/47

2-25

2-380-2-10

Evidence for change of age shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

02490

Reg. Dist. No. 4-2

FILM No. G 11 MAY 8 1947

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay 27, Md.
(If outside city or towe limits, write RURAL aod give nearest town)
How long in above place of death? 4-16-46
Hospital, Institution, or street address where death occurred:
Relay Sanitarium
How long in hospital or institution? 4-16-46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Mary Virginia Carr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Stuart R. Carr
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 22, 1864

8. AGE: Years	Months	Days	If less than one day
82 83	5	18	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John C. Schaefer
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mrs. [illegible] Highleyman
15. Birthplace

16. Informant: Mrs. Robt. Highleyman
Address: 4327 Marble Hall, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20/47 (month) (day) (year)
Tux. 6100
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave
18. Funeral director: John O. Mitchell & Sons
Address: 1900 Eutaw Place

19. 3/19 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-18-47 19..., at 10:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16-46 19... to 3-18-47 19...
and that I last saw her alive on 3-18-47 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to: Cerebral arteriosclerosis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lewis P. Tumbs M.D.
M. D. or other
Address: Relay 27, Md. Date signed: 3-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

02491

Reg. Dist. No. 440

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in-hospital or institution? 69 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Vienna
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 15
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: CLAYTON CAUSEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Pauline Causey

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): 11-15-15

8. AGE: Years	Months	Days	If less than one day
31	3	23	...hrs. ...min.

9. Birthplace: Fruitland, Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Not known
13. Birthplace:

MOTHER
14. Maiden name: Not known
15. Birthplace:

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 11 1947 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: East New Market Md

18. Funeral director: Edsworth Armacost
Armacoast Funeral Home

Address: 4204 Ridgeway Ave., Baltimore, Md.

19. Mar 8-47 (Date rec'd by registrar) 19... D. T. Trashy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947 at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29 1946, to March 8 1947 and that I last saw him alive on March 8 1947

	DURATION
Immediate cause of death: UREMIA	
Due to: Chronic Glomerula nephritis	58 days
Due to:	69 days plus
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D., CLIN. DIR.
V.A.H. FORT HOWARD, M.D.

Address: ... Date signed: 3/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Baltimore — Registration Dist. No. 31

Village or City Harrisonville Md. — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

2. FULL NAME G. Herbert Childs — If U. S. Veteran, specify WAR —

(a) Residence: No. Brightside Ave — St., — Ward. — If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Childs

6. DATE OF BIRTH (month, day, and year): Aug 4 - 1881

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	7	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Gardner

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year): — 11. Total time (years) spent in this occupation: —

12. BIRTHPLACE (city or town) (State or country): Maryland

FATHER

13. NAME: John C. Childs

14. BIRTHPLACE (city or town) (State or country): Howardsville Maryland

MOTHER

15. MAIDEN NAME: Mary Delbaugh

16. BIRTHPLACE (city or town) (State or country): Balto Co. Md.

17. INFORMANT: Mrs Thomas Windsor

(Address) 13 Hawthorne Ave

18. BURIAL, CREMATION, OR REMOVAL

Place: Druid Ridge — Date: March 8, 1947

19. UNDERTAKER: Ellsworth Armacost

(Address) 3911 Liberty Heights Ave

20. FILED 3/7/, 1947 — Jno. E. Martin, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March, 193 — (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19...; deeth is said to have occurred on the date stated above, at ... m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	

Other Contributory Causes of importance:

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or Injury in eny way related to occupation of deceased? No

If so, specify

(Signed) Wm. E. Martin, M. D.

(Address) Randallstown Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

02492

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2314 E. Baltimore St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: NICOLA CIRIO (CERIO)

3.(b) Social Security Number: 217-18-1668

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Emilia Cirio

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 7-27-1895

8. AGE: Years	Months	Days	If less than one day
51	8	4	..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Cement Finisher

11. Industry or business:

FATHER
12. Name: Francis Cirio
13. Birthplace: Italy

MOTHER
14. Maiden name: Unknown
15. Birthplace: Italy

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4-47 (month) (day) (year)
Cemetery or crematory: Balto. National Cem
Location: Frederick Rd.

18. Funeral director: John L. Miller
Address: 2334 Jefferson St.

19. April 2 19 47 (Date rec'd by registrar) A. W. Bedsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 19 47 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 19 47, to March 31 19 47 and that I last saw him alive on March 31 19 47

Immediate cause of death	DURATION
ADENOCARCINOMA OF STOMACH WITH	2 yrs. plus
REGIONAL METASTASIS	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. C. Newnam, M.D. M. D. or other

Address: Vets. Adm. Fort Howard, Md. Date signed: 3/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

02493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3/0

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
6700 Dogwood Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6700 Dogwood Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Donald Clarke

3.(b) Social Security Number: 217-20-8531

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie M. Clarke
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): January 23, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	11	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Henry Edwards Clarke
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary S. Sangston
15. Birthplace: Calvert County, Md.

16. Informant: Mrs. Elsie M. Clarke
Address: 6700 Dogwood Rd., Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5, 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn, Md.
18. Funeral director: Miller Lamborn
Address: 4510 Liberty Heights Ave.

19. Mar 4 1947 (Date rec'd by registrar) A. W. Bedsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1947, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2 1946 to March 2 1947
and that I last saw him alive on March 2 1947

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	1 yr.
Due to	
Due to	
Other conditions Cerebral Apoplexy	8 mos

(Include pregnancy within 3 months of death)

Major findings of operations: no operation — Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Joshua H. Armacost M.D. (M. D. or other)
Address: 6419 Windsor Mill Rd. Date signed: Mar. 3 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131a)

3371

CERTIFICATE OF DEATH

Reg. Diat. No. 36

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years, 5 months, 13 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 15 years, 5 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Climm

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 30, 1886

8. AGE: Years	Months	Days	If less than one day
61	1	11	hrs. min.

9. Birthplace: Philadelphia
(Town, county, and state)

10. Usual occupation: Stenographer

11. Industry or business: None

FATHER
12. Name: Alexander Climm
13. Birthplace: Hungary

MOTHER
14. Maiden name: Louisa Weber
15. Birthplace: New York

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-30-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 4-30-1947 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1947, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28, 1931, to March 13, 1947, and that I last saw him alive on March 13, 1947.

Immediate cause of death	DURATION
Chronic sclerotic coronary disease	indefinite
Cardiac dilatation - hypertensive	"
Due to: cardiovascular-renal disease	"
Splenomegaly -undetermined cause	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Catonsville-28, Md. Date signed: 4-7-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02494 41

Reg. Dist. No.

1. PLACE OF DEATH:
County Turners Station
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Linden Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Coleman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1911

8. AGE: Years	Months	Days	If less than one day
35			hrs. min.

9. Birthplace Mississippi (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Robert Joyner
13. Birthplace N.C.
MOTHER 14. Maiden name Pauline Pearl ?
15. Birthplace N.C.
16. Informant Pauline Lyons
Address 109 Linden Court.
17. Buried (Burial, cremation, or removal. Which?) Date thereof March 5/47 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.
18. Funeral director Mrs. Pott & Elbert Dyk.
Address 1129 N. Caroline St
19. 3/5/47 (Date rec'd by registrar) 19 C.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1, 1947, to March 5, 1947 and that I last saw h.. alive on March 5, 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	2 Days
Due to —	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Hall, M.D. M. D. or other
Address 140 Oak Ave Date signed 3-5-47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

Evidence for the addition of place of residence is shown on C 109 3/31/47

02495

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Diat. No. 301

1. PLACE OF DEATH:
County: Balto —
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos
Hospital, institution, or street address where death occurred: Hood Nursery Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Elizabeth Crampton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F Female	W	W.

6.(b) Name of husband or wife: John Ed. Crampton
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 3, 1868

8. AGE:

Years	Months	Days	If less than one day
78	8	11	..... hrs. ..... min.

9. Birthplace: D. C.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: ?
13. Birthplace

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: D. C.

16. Informant: Chas. E. Crampton
Address: Wash. D. C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mon. 15, 1947 (month) (day) (year)
Cemetery or crematory
Location: Washington D.C.
18. Funeral director: W. W. Deal
Address: 4812 Georgia Ave N.W.

19. 3-15 1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 14 1947, at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Mar 14 1947 and that I last saw h.. alive on Mar 14 1947

Immediate cause of death	DURATION
Due to Myocarditis	3 Mon
Due to Arteriosclerosis	
Due to Cerebral Vas. Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Jesse M. Sowell M. D. or other
Address: Catonsville Date signed: 3/15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02496 38 P

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. Presbyterian Home

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Emma L. Curn

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife Patrick J. Curn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1854

8. AGE: Years	Months	Days	If less than one day
92	3	1	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business .....

FATHER 12. Name Charles H. Davis

FATHER 13. Birthplace Mass.

MOTHER 14. Maiden name Eliz. Miller

MOTHER 15. Birthplace Pa.

16. Informant Records - Presbyterian Home

Address .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/47 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemy.

Location Fred. Ave. Balto. Md.

18. Funeral director John O. Mitchell & Sons

Address 1900 Eutaw Place

19. 3/28 (Date rec'd by registrar) 19 47 A. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 4:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 22, 1947, to March 25 1947 and that I last saw h.r alive on March 26, 1947

Immediate cause of death	DURATION
Apoplexy	3 days
Due to Arteriosclerosis & Hypertension	chr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hunt Heller M.D.

M. D. or other

Address Towson 4 Md. Date signed 3/28/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 I Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 02497
(c) City or town Sparrows Pt. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 I. Street Sparrows Pt
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/47

8. **AGE:** Years | Months | Days | If less than one day hr. min.
1

9. Birthplace Sparrows Pt. Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Fred Davis
13. Birthplace N.C.

MOTHER
14. Maiden Name Grace Hayes
15. Birthplace Va

16 (a) Informant Fred Davis
(b) Address 620 I. St Sparrows Pt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Dundalk, Md.

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) Mar 5 (Date rec'd by registrar) (b) A. W. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1947, at 3300 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3rd 1947 to March 4th 1947, and that I last saw him alive on March 4th 47

Immediate cause of death	Duration
Umbilical Hemorrhage	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. **Signature** D. H. Thomas M.D. M. D.
Address Dundalk Sta MD Signed

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Near Granite
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Granite
(If outside city or town limits, write RURAL and give nearest town)
Street No. Greenwood Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Williams Bell

3. (b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Cenia Hartman
6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) April 19, 1880

8. AGE:

Years	Months	Days	If less than one day
66	10	24	...hrs. ...min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John N. Bell
13. Birthplace Md

MOTHER
14. Maiden name Emma Stansfield
15. Birthplace Md.

16. Informant Mrs Cenia Bell
Address Woodstock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 19, 1947 (month) (day) (year)
Cemetery or crematory Wards Chapel Cemetery
Location Liberty Rd., Balto Co. Md

18. Funeral director C. Harry Wees
Address Sykesville, Md.

19 3/17/47 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Mar. 15, 1947
and that I last saw him alive on Mar. 14 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randallstown Date signed 3/17/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

02498

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Balto
City or town Carney (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
8913 Clement Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto. Co.
City or town Carney (If outside city or town limits, write RURAL and give nearest town)
Street No. 8913 Clement Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Stanley N. DeMoss

3.(b) Social Security Number 217-05-1744

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Florence A. DeMoss
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 6th 1894

8. AGE: Years	Months	Days	If less than one day
52	9	15	..... hrs. ..... min.

9. Birthplace Balto. Co. Md (Town, county, and state)
10. Usual occupation Mechanic
11. Industry or business Black & Decker

FATHER
12. Name Joel G. DeMoss
13. Birthplace Harford Co. Md

MOTHER
14. Maiden name Anne Bears
15. Birthplace Harford Co. Md.

16. Informant Mrs. S. N. DeMoss
Address 8913 Clement Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 24 47 (month) (day) (year)
Cemetery or crematory Moreland Memorial Park
Location Balto. Co. Md.
18. Funeral director Lassahn Funeral Home
Address 7407 Belair Rd.
19. 3/22/47 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1947, at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to 3/21 1947
and that I last saw h alive on 3/21/47 1947
Immediate cause of death Coronary Thrombosis — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard Gallon, M. D. or other
Address 5103 Harford Rd Date signed 3/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 12499

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rose Hill
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Harvey Reed Dixon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie P. Dixon

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 24, 1874

8. AGE: Years	Months	Days	If less than one day
72	7	25	..... hrs. ..... min.

9. Birthplace: Frederick Co.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Benjman S. Dixon
13. Birthplace: Frederick Co.

MOTHER
14. Maiden name: Amanda Thomas
15. Birthplace: Frederick Co.

16. Informant: Nellie P. Dixon
Address: Pikesville 8, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 24, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick, Md.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. 3-24-1947 (Date rec'd by registrar) Mary P. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1947, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-23 1936, to 3-21 1947, and that I last saw him alive on 3-19 1947

Immediate cause of death	DURATION
Metastatic Carcinoma	1 yr.
Due to: Carcinoma of Prostate	2 yrs. Est.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. D. Eagles, M.D.
M. D. or other

Address: Reisterstown, Md. Date signed: 3-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

02500 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Diat. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Baltimore
County
City or town Oak Park Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. Brady Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Duckett

3.(b) Social Security Number

4. Sex M
5. Color or race C
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Elmira Duckett
6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) June 23 - 1877
8. AGE: Years 69 Months 8 Days 9 If less than one day ... hrs. ... min.
9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Emma Duckett
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/47 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location Brooklyn Md
18. Funeral director Guy O. Wilson
Address 1000 Brantley Ave
19. 3-4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1947, at 3:30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 43 to Mar 2 1947
and that I last saw h- alive on Feb 25 1947
Immediate cause of death

	DURATION
Arteriosclerosis	4 yr.
Due to with Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Larson M. D.
M. D. or other
Address 1711 Selma Ave Date signed 3/4/47

71

330 AM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

CERTIFICATE OF DEATH

02501

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Sparrows Point 19.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7306 Betz ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: David Edwards

3. (b) Social Security Number: 213-07-0752

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White.	Married

6.(b) Name of husband or wife: Marguerita Dugan Edwards
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1893

8. AGE: Years	Months	Days	If less than one day
53	4	19	...hrs. ...min.

9. Birthplace: Wales England
(Town, county, and state)
10. Usual occupation: Repair Man
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: John Howells
13. Birthplace: Wales

MOTHER
14. Maiden name: Hannah Edwards
15. Birthplace: Wales

16. Informant: Mrs. Marguerita Dugan Edwards
Address: 7306 Betz avenue, Sparrows Point

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 26/47 (month) (day) (year)
Cemetery or crematory: Oaklawn
Location:

18. Funeral director: Chas. G. Evans & Son, Inc.
Address: 118 N. Mt. Royal Ave.

19. March 25, 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 23 1947, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 23 1947, to Mar 23 1947,
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Internal body, chest & abdomen crushed.	
Due to: Multiple fractures Compound & comminuted	
Due to: Many bones	
Other conditions: Heart, liver & lungs very badly crushed out of body.	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide~~, ~~homicide~~. Accident. Date of: Mar 23/47
Where did injury occur? Sparrows Pt. (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Industry.
Means of injury: Crane Injured at work?

23. SIGNATURE: J. M. Learmonth M.D.
M. D. or other
Address: Dundalk, Md. Date signed: 3-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4230

P

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 1 month, 18 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 years, 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Halethorpe - Baltimore 27
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3216 Rosalie Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Anna E. Ehrenfeld

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles Ehrenfeld
6.(c) If alive, give age: 80? years

7. Birth date of deceased (mo., day, yr.): August 22, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	5	hrs. min.

9. Birthplace: Maryland (Ft. McHenry)
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: Michael R. Tyrrell
13. Birthplace: Dublin, Ireland

MOTHER
14. Maiden name: Margaret Kirby
15. Birthplace: Maryland (Upper Marlboro)

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 31, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 3/28 1947 (Date rec'd by registrar) A.W. Hedrick DR Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947 at 12:40p M

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from February 9 1944 to March 27 1947 and that I last saw h...er ...alive on March 27 1947

Immediate cause of death	DURATION
1) Chronic myocarditis	indef.
2) Chronic adhesive pericarditis	"
Due to 3) Hydrothorax	48 hours
4) Chronic interstitial	
Due to nephritis	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatinns: ... Date of op. ...
Aotopsy resolts: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other
Address: Catonsville-28, Md. Date signed: 3-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of age is shown on G 109 3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02503

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
502 Riverside Drive.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Riverside Drive.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lillian Mae Ely.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Separated

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 20 - 1903

8. AGE: Years 43 | Months 4 4 4 3 & 6 MONTHS | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual occupation at Home.

11. Industry or business —

FATHER 12. Name John J. Pfeifer
13. Birthplace Balto. Md.

MOTHER 14. Maiden name Anna, Ketchum
15. Birthplace Balto. Md.

16. Informant Margaret Kuegler. (Daughter)
Address 502 Riverside Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/26/47 (month) (day) (year)

Cemetery or crematory Oak Lawn.
Location Eastern Ave. Rd.

18. Funeral director John A Connelly.
Address 418 Eastern Ave. Essex 21, Md.

19 Mar. 24 19 47 John J. Connelly Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 47, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 46, to Mar 23 19 47
and that I last saw h.. alive on Mar 23, 1947 19

Immediate cause of death	DURATION
Carcinoma Uterus	1 yr.
Due to ?	
Due to ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas B. Kegley M.D. Hagerstown
M. D. or other
Address 515 Eastern Ave Date signed 3/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-440-1-10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. [illegible]

G49546

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4749 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 02504
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Ender

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1880

8. AGE: Years 66 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Reis
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Weyert
15. Birthplace Germany

16 (a) Informant Emil Ender
(b) Address 4709 Wilkens Ave

17 (a) Buried (b) Date thereof 3/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1600 Pennsylvania Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1947, to Mar 14 1947 and that I last saw her alive on Mar 14 1947.

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Hypertensive Cardio-Vascular disease	Unknown
Due to:	
Other Conditions: Exfoliative dermatitis, pneumonia etiology	Unknown

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence B. Thomas M. D.

Address 4707 Frederick Ave Date signed 15 Mar 47

VS 150 1-35

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02505

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: Spring Grove Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Bladensburg Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 4635 Lacey Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Susie Tennall

3.(b) Social Security Number:

4. Sex	5. Color of race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Williams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1859

8. AGE: Years: 88 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Home

11. Industry or business

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mary Hill

MOTHER — 15. Birthplace: Maryland

16. Informant: Minnie Tennall

Address: 4635 Lacey ave. Bladensburg Park. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: March 31, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: Robert A. Mattingly

Address: 1311 11th St. S.E. Washington D.C.

19. 3-31-1947 (Date rec'd by registrar) Harry L. Myler Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15 1947, to Mar 27 1947

and that I last saw h... alive on Mar 27 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Howard Stowell M. D. or other

Address: Laconia Md. Date signed: 3/27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02506 30
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Haarlem Lodge
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1227 N. Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Bertha A. Fiorentino

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Frank Fiorentino
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1896

8. AGE: Years: 50 | Months: 4 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Fred Schlegel
13. Birthplace: Germany

MOTHER
14. Maiden name: Johanna Fiorentino
15. Birthplace: Germany

16. Informant: Frank Fiorentino
Address: 1227 N. Charles St.

17. (Burial, cremation, or removal. Which?) General Date thereof: Mar. 23, 1947 (month) (day) (year)
Cemetery or crematory: Government
Location: Philadelphia, Penna.

18. Funeral director: Williams Cook Inc.
Address: 1217 St. Paul St.

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 47, at 9.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-9 19 47, to 3-22 19 47
and that I last saw her alive on March 22 19 47

Immediate cause of death: Cardiac failure — DURATION: 13 days
Due to:
Due to:
Other conditions: Syphilis, Duodenal ulcers
(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Vernon Williamson M.D.
M. D. or other
Address: 201 Hilton Ave. Catons. (28) Md. Date signed: 3/24/47

I-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 127-a

CERTIFICATE OF DEATH

02507

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 209 Beaumont Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 209 Beaumont Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John F. Fitschen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Gladys D. Fitschen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1884

8. AGE: Years	Months	Days	If less than one day
62	3	14	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Records + Goldsborough

FATHER
12. Name Wm. Fitschen
13. Birthplace Md.

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mrs. Gladys D. Fitschen
Address 209 Beaumont Ave

Cremation (Burial, cremation, or removal. Which?) Date thereof 3/24/47. (month) (day) (year)
Cemetery or crematory Loudon Pk.
Location 3801 Frederick Road
18. Funeral director Harry A. Tuttle
Address 4101 Edmondson Ave.

19. 3/23 19 47 Harry W. Miller Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/47. 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 19 46 to March 22 19 47
and that I last saw h... l... alive on March 22 19 47

Immediate cause of death Cardiac dilatation + failure — DURATION 3 hrs

Due to Terminal hypostatic pneumonia — 1 day

Due to Probable adrenal insufficiency — 2 weeks

Other conditions Chronic cholecystitis — Unknown

(Include pregnancy within 3 months of death)

Major findings of operations Chronic cholecystitis.
Date of op. Jan. 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Stephen Lee Magness M.D.
M. D. or other
Address 752 Frederick Ave Date signed 23 March 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 834

CERTIFICATE OF DEATH

★ 02509

Reg. Dist. No. 381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore,
City or town: Towson,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Presbyterian Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore,
City or town: Towson,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Presbyterian Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Amanda S. Floyd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1861

8. AGE: Years	Months	Days	If less than one day
85	5	14	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Charles J. Floyd
13. Birthplace: Va.

MOTHER — 14. Maiden name: Amanda E. Senseney
15. Birthplace: Md.

16. Informant: Mrs. T. E. Elliott Supt.
Address: Presbyterian Home, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 3, 1947 (month) (day) (year)
Cemetery or crematory: Green Mount Cemy.
Location: Baltimore, Md.

18. Funeral director: John C. Mitchell & Sons
Address: 1900 Eutaw Place

19. March 3 1947 (Date rec'd by registrar) Carroll Lawton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1947 at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15. 1947 to Feb 28 1947
and that I last saw h... alive on Feb 28. 1947

Immediate cause of death	DURATION
Apoplexy	9 weeks
Due to Arteriosclerosis & Hypertension	unk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hunt Green M.D. M. D. or other
Address: Towson 4, Md. Date signed 3/3/47.

2-25

2-380 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02508

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:
Hanover Road Reisterstown

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hanover Road
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Ida E Beverly Flynn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Capt George F Flynn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 2 1855

8. AGE: Years	Months	Days	If less than one day
92	2	4	..... hrs. ..... min.

9. Birthplace: Machias Washn Co Maine
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER
12. Name: John Beverly
13. Birthplace: Whiting Maine

MOTHER
14. Maiden name: Drucilla West
15. Birthplace: Gardner Lake Maine

16. Informant: Ernest A Flynn
Address: Hanover Rd Reisterstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8 1947 (month) (day) (year)

Cemetery or crematory: St Paul's Cemetery

Location: Arcadia Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. 3-8-1947 (Date rec'd by registrar) Mary B Elins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 / 6 / 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14/44 to 3/6/47

and that I last saw h[illegible] alive on 3/5/47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to:	
Due to: arteriosclerosis	
Other conditions: -	

(Include pregnancy within 3 months of death)

Major findings of operations: - Date of op.: -

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other

Address: Reisterstown Md Date signed 3/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

02510

Reg. Dist. No. [redacted]

1. PLACE OF DEATH:
County: Rosemont, Baltimore County
City or town: Rosemont
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: —
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rosemont
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Catherine M. Foley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Patrick J. Foley
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 8, 1881

8. AGE: Years	Months	Days	If less than one day
65	3	8	....hrs. ....min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Unknown
13. Birthplace:

MOTHER — 14. Maiden name: Unknown
15. Birthplace:

16. Informant: Mrs. Wm. Cline
Address: 3026 Tenn. Ave., Rosemont

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 15, 1947 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Baltimore

18. Funeral director: Wm. Cook, Inc.
Address: 1217 St. Paul Street

19. Mar 15 1947 (Date rec'd by registrar) A. W. Vollmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1947, to Mar 12 1947
and that I last saw h[illegible] alive on Mar 12 1947

Immediate cause of death	DURATION
Cardiac - Vascular renal disease	1 yr.
Due to	
Due to	
Other conditions Complete Bi Lapse	5 yr

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Bace Jr. MD M. D. or other
Address: Catlicum — Date signed 3-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02511

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5701 Second Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5701 Second Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie M. Gahm
3.(b) Social Security Number

4. Sex: Female
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Late Frederick Gahm
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 25, 1864
8. AGE: Years 82 Months 2 Days 24 If less than one day ... hrs. ... min.
9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: H.W.
11. Industry or business
FATHER 12. Name: Andrew Weigand
13. Birthplace: Germany
MOTHER 14. Maiden name: Eva Spring
15. Birthplace: Germany
16. Informant: Mrs. Lottie Hughes
Address: 5701 Second Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/22/47. (month) (day) (year)
Cemetery or crematory: Loudon Pk.
Location: 3801 Frederick Rd.
18. Funeral director: Harry H. Witzke
Address: 4101 Edmondson Ave
19. March 21 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch. 19/47. 19..., at A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Mch 19 1947
and that I last saw her alive on Mch 17 1947

	DURATION
Immediate cause of death: Cerebral haemorrhage	5 days
Due to: arterio sclerosis	
Due to:	
Other conditions: Myocarditis c̄ heart failure	48 hrs

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Frederic J. Beeler M. D. or other
Address: 723 Medical Arts Bldg Balto Date signed: 3-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1)

CERTIFICATE OF DEATH

02512

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Braeside (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? in U.S.A. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5224 Cromarty Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Veronica L. Gaither

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Stanley D. Gaither
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Aug 15, 1873.

8. AGE:

Years	Months	Days	If less than one day
73	6	16	...hrs. ...min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:

FATHER
12. Name: Anthony Aleksna
13. Birthplace: Lithuania

MOTHER
14. Maiden name: Anna Gaukus
15. Birthplace: Lithuania

16. Informant: Stanley D. Gaither
Address: 5224 Cromarty Road.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Mar 6, 1947 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: City
18. Funeral director: Mrs. Mrs. John F. Feifel-Son
Address: 5311 Edmondson Ave.

19. 3-6-1947 (Date rec'd by registrar) Harry L. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 3 1947 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 1947 to March 3 1947 and that I last saw her alive on March 3 1947

Immediate cause of death	DURATION
Disease: myocarditis	3 yrs.
Due to: Hypertensive Cardio Vascular Disease (Arteriosclerosis)	5 yrs.
Due to:	
Other conditions: Cerebral Thrombosis with softening of brain	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John P. Ulrich Jr. M. D. or other
Address: 1225 Wash. Blvd. Date signed: 3/4/47

1-36

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d ★ 02513

Reg. Dist. No. 21 0

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 68 Northshire Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gerhard J. Galster

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary A. Galster
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 30, 1879

8. AGE:

Years	Months	Days	If less than one day
67	5	27	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Book Binder
11. Industry or business: American Bank Stationary
FATHER 12. Name: Matthew Galster
13. Birthplace: Md.
MOTHER 14. Maiden name: Alvina
15. Birthplace: Md.
16. Informant: Mrs. Mary A. Galster
Address: 68 Northshire Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 31, 1947 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Road
18. Funeral director: Roland L. Fuhrer
Address: 2112 Dundalk Ave.
19. (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 47, at 2:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Coronary Occlusion	10 Min.
Due to: A.S.C.V. Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M Bears M.D.
Deputy Medical Exam. M. D. or other C.
Address: Dundalk Date signed: 3/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02514

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: BALTIMORE
City or town: CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
315 INGLESIDE AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: BALTIMORE
City or town: WOODBROOK
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOSEPHINE G. GARDELL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	SINGLE

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): DEC. 28, 1867

8. AGE: Years	Months	Days	If less than one day
79	2	23	..... hrs. ..... min.

9. Birthplace: SOMERSET CO. MD.
(Town, county, and state)
10. Usual occupation: HOUSEKEEPER
11. Industry or business
FATHER 12. Name: JOSEPH GARDELL
FATHER 13. Birthplace: GERMANY
MOTHER 14. Maiden name: CAROLINE KRONE
MOTHER 15. Birthplace: PENNA.
16. Informant: MRS. EMMA C. STRAUB
Address: 310 E. UNIVERSITY PKWY.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: MAR. 24 1947 (month) (day) (year)
Cemetery or crematory: NEW CATHEDRAL
Location: BALTIMORE
18. Funeral director: WILLIAM COOK, INC.
Address: 1217 ST. PAUL ST.
19. March 21 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 47, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 19 47, to March 21 19 47 and that I last saw h.er alive on March 21 19 47

Immediate cause of death	DURATION
Cerebrovascular accident	2 yrs
Heart disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Jos. A. Kirkman, Md. M. D. or other
Address: Ellicott City Md. Date signed: 3/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03383

Reg. Dist. No. 3

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Old Court Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Court Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert P. Gettier

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mollie J. Gettier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 2, 1860

8. AGE: Years	Months	Days	If less than one day
87	2	11	..... hrs. ..... min.

9. Birthplace: Reisterstown, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: William P. Gettier
13. Birthplace: Hampstead, Md.

MOTHER
14. Maiden name: Jeminia V. Cross
15. Birthplace: Soldier's Delight, Md.

16. Informant: Mrs. Edward Fryfogle
Address: Old Court Road, Randallstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: [signature]

Address: 4510 Liberty Heights Ave.

19. 3/14/47 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1947, at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1947, to March 13, 1947

and that I last saw him alive on March 12th 1947

Immediate cause of death	DURATION
Chronic Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Harrisonville, Md. Date signed 3/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-0

CERTIFICATE OF DEATH

02515

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
8 Cedarwood Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Cedarwood Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ada O. Gies

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife: Late J. Franklin Gies
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1880

8. AGE: Years	Months	Days	If less than one day
66	8	4	..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: H/ W.
11. Industry or business

FATHER
12. Name: George R. Beaver
13. Birthplace: Pa.

MOTHER
14. Maiden name: Laura Wilfong
15. Birthplace: Pa.

16. Informant: Oscar R. Gies
Address: 8 Cedarwood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/47 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Reisterstown, Md.
18. Funeral director: Harry H. Lubkin
Address: 4101 Edmondson Ave.
19. 3-18 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to March 16 19 47
and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Acute Dilatation of Heart	30 min
Due to Hypertension	yrs
Due to Myo-Endocarditis	yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Herbert M. Foster M. D. or other
Address: 2524 St. Paul St. Date signed: March 17 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

★ 02516 Reg. Dist. No. 320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Howardsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Cobb Nursing Home - South
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Howardsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Campfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Katherine Anna Gompf

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): NOV. 15-1857

8. AGE:

Years	Months	Days	If less than one day
89	4	15	..... hrs. ..... min.

9. Birthplace: Baltimore
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Peter Gompf
13. Birthplace: Germany
MOTHER 14. Maiden name: Katherine Schott
15. Birthplace: Germany
16. Informant: Mrs. Clarence Pahl
Address: Campfield Rd. Howardsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2- 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Randallstown, Md.
18. Funeral director: Frank H. Newell
Address: Pikesville, Maryland
19. 4-1-1947 (Date rec'd by registrar) Dr. F. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16th 1946, to Mar. 30th 1947 and that I last saw her alive on Mar. 29th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wk.
Due to: Hypertension	2 yrs.
Due to:	
Other conditions: Art. Sclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Miller M.D. M. D. or other
Address: Pikesville-8, Md. Date signed: 3/31/47

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14C)

CERTIFICATE OF DEATH

02517

Reg. Dist. No. 301

1. PLACE OF DEATH

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 Egges Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Oliver Grimes

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Isabelle E. Scrivenor

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 7, 1874

8. AGE:

Years	Months	Days	If less than one day
72	3	12	.... hrs. .... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER

12. Name: George Washington Grimes

13. Birthplace: Md.

MOTHER

14. Maiden name: Louise Snyder

15. Birthplace: Md.

16. Informant: Mrs Isabelle Grimes

Address: 17 Egges Lane, Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof: 3-21-47 (month) (day) (year)

Cemetery or crematory: Oak Grove Cemetery

Location: Glenwood, Howard Co. Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. 3/22 19 47 Harry W. Miller (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch. 19, 47 about 12-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death	DURATION
Gun shot wound in Chest	
Due to	
Due to: suicide	
Other conditions: 12 Shot gun	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: Mch. 19. 47

Where did injury occur? Catonsville (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Shot in chest with 12 gun. Injured at work? no

23. SIGNATURE: Geo. M. Kieffer, Dep. Med. Exam. of Balto. Co. M. D. or other

Address: 1010 Reeds Ave. Date signed: 3-20-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

02518 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County... Balto.

City or town... Eastern Ave Chase Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. Eastern Ave

(If rural, give LOCATION)

2.(a) If veteran, name war...

3.(a) FULL NAME Rosie Miller Grimage

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Widow

6.(b) Name of husband or wife Benjamin

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 29, 1890

8. AGE: Years 56 Months Days If less than one day ... hrs. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Connick

13. Birthplace Md

MOTHER 14. Maiden name Susie Travis

15. Birthplace Md.

16. Informant William Grimage

Address Eastern Ave Chase Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17/47 (month) (day) (year)

Cemetery or crematory Sharp St Cemetery

Location Chase Md

18. Funeral director Mrs. Robert A. Elliott, Dgt.

Address 1129 N. Caroline St

19. March 17 1947 A W Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 9:54A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1947, to March 14 1947

and that I last saw her alive on March 14 1947

	DURATION
Immediate cause of death Cerebral apoplexy	2 days
Due to Arteriosclerotic Cardio Vascular disease With	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE W Wallace Graham M. D. or other

Address Balto Md Date signed 3-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

02519

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 1916 Old Frederick Road
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1916 Old Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George A Groenanger

3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Frances
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept 6 1871
8. AGE: Years: 75 Months: 6 Days: 22 If less than one day ..... hrs. ..... min.
9. Birthplace: Balt Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Fred Groenanger
13. Birthplace: Germany
MOTHER 14. Maiden name: Veronica Wessel
15. Birthplace: Germany
16. Informant: Mrs. H C Hoffmann
Address: 1916 Old Fields Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-47 (month) (day) (year)
Cemetery or crematory: Cedar Lawn
Location: Balt Md
18. Funeral director: George C Talley
Address: Catonsville Md
19. 3/31/47 19..... Harry W Miller Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March - 28 19 47, at 9:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 19 46, to March 28 19 47 and that I last saw him alive on March - 27 - 19 47.

	DURATION
Immediate cause of death: Myocardial Degeneration	1 yr.
Due to: Senility - etc	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J. Lloyd Johnson M. D. or other
Address: Catonsville Md Date signed 3-28-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02520

CERTIFICATE OF DEATH

46f

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Brighton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Brighton (If outside city or town limits, write RURAL and give nearest town)

Street No. 6728 Brighton Ave (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME David L. Grove

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lillian M.

Social Security # 220-01-2681 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1899

8. AGE: Years	Months	Days	If less than one day
47	8	19	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Bricklayer

11. Industry or business Building

FATHER 12. Name Francis J. Grove

FATHER 13. Birthplace Manchester, Carroll Co., Md

MOTHER 14. Maiden name Minnie Shatz

MOTHER 15. Birthplace Baltimore, Maryland

16. Informant Mrs. Lillian M. Grove

Address 6728 Brighton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-22-47 (month) (day) (year)

Cemetery or crematory Baltimore National

Location Baltimore, Maryland

18. Funeral director Loring Byers

Address 5005 Park Heights Ave

19. March 21, 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 19 47 at 11 35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-19, 19 47 to 3-19 19 47 and that I last saw h... alive on 3-19-47 19..

Immediate cause of death	DURATION
Ca of Liver	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. J. Abbott M. D. or other

Address 4509 Liberty Heights Ave Date signed 3-21

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (737)

CERTIFICATE OF DEATH

02521 44

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore - 19 -
City or town: Jones Creek.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day.
Hospital, Institution, or street address where death occurred: 7308 Walnut Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltto - 19.
City or town: Jones Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ketchum Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Eleanor Groves.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife: John Henry Groves
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): January 6, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	23	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: own home

FATHER
12. Name: Henry Ropelt.
13. Birthplace: Germany.

MOTHER
14. Maiden name: Elizabeth Miles
15. Birthplace: England

16. Informant: Mrs Minnie Mc Donald
Address: 7308 Walnut ave Balto-19

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/47 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. Mar 4 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 1 19 47 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 19 47, to Mar. 1 19 47.
and that I last saw h.. alive on Mar. 1. 19 47.

Immediate cause of death	DURATION
Myocardial degeneration	One day.
Myocardial failure	Sudden.
Due to: Arteriosclerosis	5 yrs.
Due to:	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Tolle M.D.
M. D. or other
Address: Sparrows Point. Md. Date signed: 3/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

02522

Reg. Dist. No. 30 1

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 8 months, 5 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 8 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Marbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: A. Lee Hanson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Louise Linton ?

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 19, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	6	..... hrs. ..... min.

9. Birthplace: Charles County, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: Alvan Hanson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jennie Miller
15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. ..... (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Baltimore, Md.

18. Funeral director: Hurst & Ryan

Address: Waldorf, Md.

19. 3-25-47 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 1947, at 1:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1945, to March 25, 1947, and that I last saw him alive on March 25, 1947

Immediate cause of death	DURATION
1) Arteriosclerotic coronary disease	-indef.
2) Left lower broncho pneumonia	17 hours
Due to 3) Chronic bilateral pulmonary tuberculosis, fibrous	indef.
Due to 4) Chronic interstitial nephritis	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 3-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Weeks
Hospital, Institution, or street address where death occurred: Rev. A. Opitz Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2941 Westwood Ave., (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Julia Eleanora Harden

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Rev. William C. Harden
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 9, 1872

8. AGE: Years	Months	Days	If less than one day
74	10	16	hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business:
FATHER — 12. Name: John W. Yingling
13. Birthplace: Md.
MOTHER — 14. Maiden name: Ann Louisa Oursler
15. Birthplace: Md.
16. Informant: Rev. William C. Harden
Address: 2941 Westwood Ave.,
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-28-47 (month) (day) (year)
Cemetery or crematory: Westminster
Location: Westminster, Md.
18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.
19. 3/27/47 (Date rec'd by registrar) A. W. Heduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 1947 at 7.00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1947 19 to March 25 1947 and that I last saw h... alive on March 25, 1947 19

Immediate cause of death	DURATION
Pneumonia	2 Dy.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Fracture of Arm Date of Feb 15 47
Where did injury occur? 2941 W. North Ave Balto. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fell out of Bed Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 3757 W. North Ave Date signed: 3/24/47

Evidence for the change of age is shown on G 109 3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

★ 02524

P

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4409 Underwood Rd. 18

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HUGO BUTE HARK

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eleanor B. Hark

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1867

8. AGE: Years	Months	Days	If less than one day
79	2	18	hrs. min.

9. Birthplace: Nazarath, Pa. (Town, county, and state)

10. Usual occupation: retired Agriculturist

11. Industry or business

FATHER — 12. Name: Joseph M. Hark

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Louisa Bute

MOTHER — 15. Birthplace: Philadelphia, Pa.

16. Informant: Mrs. Beatrice H. Crites

Address: 4409 Underwood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/5/47 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cem.

Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. Mar 5 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1947, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to March 3 1947 and that I last saw h[illegible] alive on March 1 1947

Immediate cause of death: Myocardial Insuff 6 hrs — DURATION

Due to:

Due to:

Other conditions: Prostatic Hypertrophy 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Horn E. Watson M. D. or other

Address: 3 E. Ridgely St. Date signed: 3-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

3373

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours 20 minutes
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 12 hours 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 325 Homburg Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME CHARLES HARTUNG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Mary Katherine (nee Sippel)
6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 8/6/96

8. AGE: Years	Months	Days	If less than one day
50	7	14	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
FATHER 12. Name unknown
13. Birthplace "
MOTHER 14. Maiden name "
15. Birthplace
16. Informant Clinical Records Vets. Adm. Hosp.
Address Fort Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/47 (month) (day) (year)
Cemetery or crematory Baltimore National Cem.
Location Baltimore, Md.
18. Funeral director Schimunek Funeral Home
Address 2601-3 E. Madison Street, Balto., Md.
19. 3/24 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 1:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1947, to March 20 1947 and that I last saw him alive on March 20 1947

Immediate cause of death	DURATION
arteriosclerotic heart disease with cardiac decompensation	unknown
Due to	
Due to	
Other conditions Blindness left eye due to trauma (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR. Other
Address V.A. FORT HOWARD, M.D. Date signed 3/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

02526

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dunleer Apts. B 18 Dundalk, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3.(a) FULL NAME JAMES E. HOARE

3.(b) Social Security Number 705-10-9771

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Anna Hoare
6.(c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) May 6, 1894

8. AGE: Years	Months	Days	If less than one day
52	10	7	.....hrs. .....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Railroad Conductor
11. Industry or business
FATHER 12. Name William Hoare
13. Birthplace England
MOTHER 14. Maiden name Cora Carson
15. Birthplace Maryland
16. Informant Clinical Records Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17 1947 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave. Balto. Md.
18. Funeral director Roland L. Fisher
Address 2112 Dundalk Ave. Dundalk, Md.
19. Mar 15 19 47 (Date rec'd by registrar) C. W. Kodrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 1:25a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 1947, to March 13 1947
and that I last saw him alive on March 13 1947

	DURATION
Immediate cause of death Thrombosis of anterior descending coronary artery: infarction of left ventricle: fibrinous pericarditis-	6 days
Due to Coronary arteriosclerosis	unknown
Other conditions History of hypertension, mod. arterio-sclerotic nephritis: hypertrophy of heart (Include pregnancy within 3 months of death)	unknown

Major findings of operations .....
Date of op. .....
Autopsy results "substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert M Cullison
R. H. CULLISON, CLIN. DIR. M. D. or other
Address Vets. Adm. Fort Howard, Md. Date signed 3/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02525

932

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs.-
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Baltimore
City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 mi NW of Freeland.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jennie Hoffman.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: John C. Hoffman. 6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): July 9, 1874.-

8. AGE:

Years	Months	Days	If less than one day
72	8	21	...hrs. ...min.

9. Birthplace: Parkton, Md. R.D. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home.

FATHER
12. Name: J. W. Hare.-
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Tyson.-
15. Birthplace: Md

16. Informant: Mrs. Charles Wheat
Address: Freeland, Md. R.D.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: April 2 1947 (month) (day) (year)
Cemetery or crematory: Stiltz Cemetery
Location: Glen Rock, Pa. R.D.

18. Funeral director: J. Jacob Hahnstein
Address: New Freedom Pa

19. Mar 31 1947 (Date rec'd by registrar) Calvin L. Bryan Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1947, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19.4.. to Mar 30 1947
and that I last saw h.. alive on Mar. 29 1947

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. M. Frances M. D. or other
Address: Parkton, Md. Date signed: 3/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

02527

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 317 Riverside Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Catherine Horst

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles A. Horst

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 13, 1876

8. AGE:

Years	Months	Days	If less than one day
71	0	12	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER — 12. Name: Conrad Horst

13. Birthplace: Germany

MOTHER — 14. Maiden name: Not known

15. Birthplace: Germany

16. Informant: Charles A. Horst

Address: 317 Riverside Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/47 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: O'Donnell St.

18. Funeral director: Clarence F. Hoffmann

Address: 1639 Broadway

19. March 27 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1947 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1947 to March 26 1947 and that I last saw h alive on March 25 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerotic Cardiac Vascular disease	
Due to:	
Other conditions: Diabetes.	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. M. Brumgardner M. D. or other

Address: Balto 6 Md Date signed 3-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

02528

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Dungarrie Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Millard A. Jenkins

3.(b) Social Security Number: 705-05-3022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gladys H. Jenkins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	14	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Transportation Analyst.
11. Industry or business: U.S. Government
FATHER — 12. Name: Major A. Jenkins
FATHER — 13. Birthplace: Balto., Md.
MOTHER — 14. Maiden name: Mary Geller
MOTHER — 15. Birthplace: Balto., Md.
16. Informant: Mrs. Gladys H. Jenkins
Address: 22 Dungarrie Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-24-47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.
19. 3/24 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 2.15

20. DATE OF DEATH: March 21, 1947, at A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26, 1946 to Mar 21, 1947 and that I last saw h. l. alive on Mar 21, 1947

Immediate cause of death	DURATION
Chronic Myocarditis;	
Duration: Several years.	
Due to: Cong. R.	
Due to:	
Other conditions: Pulmonary Edema.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George E. Shannon M.D. M. D. or other
Address: E. of Medical Arts Bldg. Date signed: 3/22/47

02529 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Spanish Pt - Balto. Co.
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred: .....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Spanish Pt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 905 E. 8th
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Mary Lewis Johnson

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widow

6.(b) Name of husband or wife Mrs C. Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12 1869

8. AGE:

Years	Months	Days	If less than one day
77	11	0	..... hrs. ..... min.

9. Birthplace Culpeper Va.
(Town, county, and state)
10. Usual occupation unemployed
11. Industry or business

FATHER
12. Name Alfred Atwell
13. Birthplace Brandy Va

MOTHER
14. Maiden name Nancy Wanzer
15. Birthplace Jefferson Co. Va

16. Informant Edward M. Atwell
Address 2616 Georgia Ave Wash. D.C. N.W.

17. Burial Date thereof 3-15-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fairview
Location Culpeper Va

18. Funeral director Jesse W. Redden
Address 436 N. Bridge St.

19. 3/13 19 47 H. W. Hedrick Dep Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 19 47, at 6 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 19 47, to March 12, 19 47
and that I last saw h.er alive on March 12, 19 47

Immediate cause of death	DURATION
Broncho-pneumonia	2 days
Due to Followed Upper Respiratory Infection	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE William S. Hale, M.D.
M. D. or other
Address 140 Oak Ave Dundalk 22, Md. Date signed 3-12-47

Evidence for change of sex of deceased shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

FILM No. G 109 APR 28 1947

1. PLACE OF DEATH:
County Baltimore Co. Md.
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County Balto.
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Seminary Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Eliza E. Jordan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Female~~ Male	Colored	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 14, 1842

8. AGE: Years	Months	Days	If less than one day
104			..... hrs. ..... min.

9. Birthplace Unknown (Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Miss Bertha Lemby
Address Seminary Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 14, 1947 (month) (day) (year)
Cemetery or crematory Pleasant Rest
Location Balto. Co. - Towson, Md.

18. Funeral director Mrs. Lee A. Hallam
Address 1631 Druid Hill Ave.

19. March 15 1947 A. W. Redner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Mar. 12 1947
and that I last saw h~~e~~r alive on Mar. 11 1947

Immediate cause of death	DURATION
Cardio-Renal Disease	1 yr.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Louis A. Jolley M.D.
M. D. or other
Address 2329 Guilford Ave. Date signed Mar. 14 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1945
1944

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

02531 P

Reg. Dist. No. 42

1. PLACE OF DEATH:
County BALTO
City or town ARBUTUS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5514 LINK. AVE
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1417 OLIVE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARGARET KAUFMANN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6.(b) Name of husband or wife GEORGE KAUFMANN
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 26 1875

8. AGE: Years	Months	Days	If less than one day
71	11	16	hrs. min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name MICHAEL WEIGAND
13. Birthplace GERMANY.

MOTHER
14. Maiden name CATH. GUETHLEIN
15. Birthplace GERMANY.

16. Informant MR. CHAS KAUFMANN
Address 1417 OLIVE ST

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MARCH. 21-47 (month) (day) (year)
Cemetery or crematory CEDAR HILL
Location A. A. Co.

18. Funeral director BERNARD C HARLE
Address 121 E WEST ST

19. March 19 1947 (Date rec'd by registrar) A. W. Hebner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH. 17 1947, at 905 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 March 1947, to 17 March 1947
and that I last saw her alive on 17 March 1947

Immediate cause of death	DURATION
Heart Failure	
Due to Degenerative Myocarditis	
Due to	
Other conditions Fracture Right Arm 10 Days	
Due to: Accidental Fall. (Include pregnancy within 3 months of death.)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Fall. Injured at work?

23. SIGNATURE Ramsey B. Thomas M. D. or other
Address 4207 Frederick Ave Date signed 18 March 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

02532

Reg. Dist. No. 372

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, Institution, or street address where death occurred:
Masonic Homes, Cockeysville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Linna Keller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 22 - 1882

8. AGE: Years	Months	Days	If less than one day
64	8	—	..... hrs. ..... min.

9. Birthplace Frostburg Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name John J. Keller
13. Birthplace Charles Co. Maryland

MOTHER 14. Maiden name Ruthema Mehama
15. Birthplace Shepherdstown Va.

16. Informant Christina P Tipton - acting Matron
Address Masonic Homes, Cockeysville Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Allegheny Cemetery
Location Frostburg Maryland

18. Funeral director Wm Cook
Address St Paul & Preston Sts. Balto Md

19. Mar 23 1947 Laur M Schroeder per C.P. Tipton acting matron
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 47, at 7:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-20-46 19 ..., to Mar 23 19 47
and that I last saw h..ex alive on Mar 22- 19 47

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Arteriosclerosis	
Due to	
Other conditions Anasarca	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D.
M. D. or other
Address Cockeysville Md Date signed 3-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-370-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02533

CERTIFICATE OF DEATH

Reg. Diat. No. 381

1. PLACE OF DEATH:
County Baltimore
~~City or~~ town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Kemper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Herman Kemper
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4 - 1864

8. AGE: Years	Months	Days	If less than one day
83	0	25	..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Michael Feebeley
13. Birthplace Ireland

MOTHER
14. Maiden name Ann Birmingham
15. Birthplace Ireland

16. Informant Mrs Helen M. Funk
Address 3912 Hanover St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April - 1 - 1947 (month) (day) (year)
Cemetery or crematory Glen Haven
Location A. A. Co. Md.

16. Funeral director Flynn - Fleming
Address 1426 Light St.

19. 4-2-1947 (Date rec'd by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 29 1947 and that I last saw h.. alive on March 29 1947

Immediate cause of death	DURATION
(a) Coronary Sclerosis	1 hr
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. A. Kershner M.D. M. D. or other
Address Edmondson md Date signed 3/31/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

★ 02534

Reg. Dist. No. 372

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
Masonic Homes Cockeysville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1303 E. North Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sallie A Kemper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Chas. A Kemper
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 - 1868

8. AGE: Years	Months	Days	If less than one day
79	2	2	hrs. min.

9. Birthplace Reading Pa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Miller
13. Birthplace U.S. - did not know section

MOTHER
14. Maiden name Hannah Alt
15. Birthplace Germany

16. Informant Laura M. Schroeder per C.P. Tipton
Address Masonic Homes Cockeysville Md

17. Burial Date thereof 3 17 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Jesaups Cemetery
Location Cockeysville Md.

18. Funeral director Wm Cook
Address St Paul + Preston Sts Balto Md

19. Mar 14 1947 Laura M Schroeder
(Date rec'd by registrar) per C. P. Tipton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mary 14 1946 to Mar 14 1947 and that I last saw h alive on Mar 13 1947

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to arteriosclerosis	
Due to	
Other conditions Cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M. D.
M. D. or other
Address Cockeysville Md Date signed 3-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-370 — 1—10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02535

Reg. Diat. No. .....

1. PLACE OF DEATH:
County ... Baltimore
City or town ... Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ... 4 years
Hospital, institution, or street address where death occurred:
6 Sudbrook Lane
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ... Md. County ... Baltimore
City or town ... Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Sudbrook Lane
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Cora nmi ~~Hiesel~~ Kiesel

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife ... John L. Kiesel
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 12 sept. 1874

8. AGE: Years	Months	Days	If less than one day
73			...hrs. ...min.

9. Birthplace ... Germany, Nurnberg (Town, county, and state)
10. Usual occupation ... H.W.
11. Industry or business .....

FATHER
12. Name ... ? Engert
13. Birthplace ... Nurnberg, Germany

MOTHER
14. Maiden name ... unknown
15. Birthplace ... Germany

16. Informant ... Mrs. Margaret Snyder
Address 6 Sudbrook Lane, Pikesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17 1947 (month) (day) (year)
Cemetery or crematory ... Holy Redeemer Cem
Location ... City

18. Funeral director ... Ulrich Funeral Home
Address 2008 Orleans St

19. March 5 1947 (Date rec'd by registrar) ... C. W. Bedsel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ... 13 March 1947 at 10:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 March 1947 to 13 March 1947 and that I last saw her alive on 13 March 1947

Immediate cause of death	DURATION
Hypertensive heart disease	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of .....
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ... Injured at work?

23. SIGNATURE Charles H. Williams M.D.
M. D. or other
Address 1331 Reisterstown Road Pikesville 8, Md. Date signed 13 March 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1910
36
74

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02536 P

131a

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 1 month 18 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1221 West Fayette Street
(If rural, give LOCATION)

2.(a) If veteran, name war: W V

3.(a) FULL NAME: Mary Knorr

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: (Unknow) Knorr

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	14	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Home

FATHER 12. Name: John Pansmith

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Elizabeth Grauling

MOTHER 15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville 28, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 3/5/47 (month) (day) (year)

Cemetery ~~or crematory~~: Balto

Location: " Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. 3-3 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st, 1947 19 at 3:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 19 45 to March 1st 19 47 and that I last saw her alive on March 1st, 1947 19

	DURATION
Immediate cause of death: Chronic sclerotic coronary disease	Indef
Due to: Arteriosclerotic C-V-R- disease	"
Due to: Diffuse glomerular nephritis	"
Other conditions: Incarcerated harnia with obstruction (Include pregnancy within 3 months of death)	" 2 days

Major findings of operations: As above

Date of op. 2/28/47

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D.
Henry C. A. Mead, M. D. or other

Address: Catonsville, 28, Md. Date signed 3/1/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

02537

Reg. Dist. No. 211

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
200 York Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 York Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ////

3.(a) FULL NAME: WILLIAM ALBERT KOCH, Sr.

3.(b) Social Security Number: 219-01-2680

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel Kieffer Koch

6.(c) If alive, give age: 61 years

7. Birth data of deceased (mo., day, yr.): April 15, 1884

8. AGE: Years	Months	Days	If less than one day
62	10	15	....hrs. ....min.

9. Birthplace: Towson, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Printer

FATHER
12. Name: Henry Koch
13. Birthplace: Germany

MOTHER
14. Maiden name: Annie Betx
15. Birthplace: Germany

16. Informant: Mrs. Ethel K. Koch
Address: 200 York Road, Towson, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1947 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery
Towson, Maryland

Location:

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. Mar. 5, 1947 (Date rec'd by registrar) W. Carroll Van Hoy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1947, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Feb. 1947, to 2 March 1947 and that I last saw h... alive on 1 March 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	9 days
Due to: Hypertension + Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert W. Allen M. D. or other

Address: 4 Bealeigh Ave., Towson Date signed: 3 March 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-25

2-380=2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02538

Reg. Dist. No. 441

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2219 Old Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JAMES KOLOUP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 10/14/91

8. AGE: Years	Months	Days	If less than one day
55	5	8	hrs. min.

9. Birthplace: Middle River, Md. (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business
FATHER 12. Name: Jacob Koloup
13. Birthplace: Poland
MOTHER 14. Maiden name: Amelia ?
15. Birthplace: Poland
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-25-47 (month) (day) (year)
Cemetery or crematory: Holy Rosary Cemetery
Location: Baltimore, Md.
18. Funeral director: J. G. Connelly
Address: 418 Eastern Ave. Essex Md.
19. 3/24/47 (Date rec'd by registrar) John G Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1947, at 5:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1947 to March 22 1947
and that I last saw him alive on March 22 1947

Immediate cause of death	DURATION
Coronary thrombosis with infarction of left ventricle	Unknown
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions: Mural thrombi in left ventricle; infarcts of lung and kidneys	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: SUBSTANTIATED ABOVE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. CLIN. DIR. or other
Address: V.A. FORT HOWARD, MD. Date signed: 3/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-440-2-40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02539

Reg. Dist. No. 430

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Raspeburg, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Philadelphia Rd. #358 Route 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elsie E. Kuehne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Henry Kuehne

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): August 6th, 1906

8. AGE: Years	Months	Days	If less than one day
40	7	11	... hrs. ... min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business:

FATHER — 12. Name: Daniel Magsamen

13. Birthplace: Baltimore County, Maryland

MOTHER — 14. Maiden name: Rose Kahler

15. Birthplace: Baltimore, Maryland

16. Informant: Mr. Henry Kuehne route 2

Address: Philadelphia Rd. #358

17. burial (Burial, cremation, or removal. Which?) Date thereof March 20th/47 (month) (day) (year)

Cemetery or crematory: Zion Lutheran

Location: Stemmers Run, Maryland

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

19. Mar. 18 (Date rec'd by registrar) 1947 Mrs. G. L. Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17th 19 47, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 19 47, to March 17 19 47 and that I last saw her alive on March 17 19 47

Immediate cause of death	DURATION
Uremia	1 month
Due to Chronic Nephritis	
Due to Arteriosclerosis with Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: G. M. Baumgardner M. D. or other

Address: Balto 6 Date signed 3-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02540 44

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Baltimore, Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 82 Gilford Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ARTHUR L. LaFLEUR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie LaFleur

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 2-13-96

8. AGE: Years	Months	Days	If less than one day
51	0	23	____ hrs. ____ min.

9. Birthplace: Worcester, Mass.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: Henry LaFleur
13. Birthplace: Canada

MOTHER
14. Maiden name: Lola Dupont
15. Birthplace: New York

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 10-47 (month) (day) (year)

Cemetery or crematory: N

Location: Worcester Mass:

18. Funeral director: Ellsworth Armacost

Address: 3911 Liberty Heights Ave

19. Filed 3-7-47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1947, at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 1947 to March 6, 1947 and that I last saw him alive on March 6, 1947

Immediate cause of death	DURATION
PNEUMOCOCCIC SEPTICEMIA AND MENINGITIS DUE TO PNEUMOCOCCUS	5 days
Due to:	
Other Conditions: Pyothorax bilaterally ~~xxx~~ Atelectasis bilaterally, Muco-purulent bronchitis	5 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. Cullison, M.D. Clinical Director
M. D. or other

Address: Fort Howard, Maryland Date signed: 3-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

931

02541

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 13 d ys

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 months 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5209 Cuthbert Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Francis Jackson LaMotte

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine Rodgers LaMotte

deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 25, 1878

8. AGE: Years	Months	Days	If less than one day
68	5	21	hrs. min.

9. Birthplace: Westminster, Md.
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: Electrical

FATHER
12. Name: George W. La. Motte
13. Birthplace: Penna.

MOTHER
14. Maiden name: Eliza Jane Sheets
15. Birthplace: Westminster, Pa.

16. Informant: Hospital Records,

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/47 (month) (day) (year)

Cemetery or crematory: Providence Ch. Cem.

Location: Gamber, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 3/17 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1947 19 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 3, 1946 19 to March 16 1947

and that I last saw him alive on March 16, 1947 19

	DURATION
Immediate cause of death: Bronchopneumonia	11 hours
Due to: Generalized arteriosclerotic	
C-V-R Disease	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead, M. D.
Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed 3/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02542 P

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years 8 months 16days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 years 8 months 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 N. Linwood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Langkam, John

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male M	white	married

6.(b) Name of husband or wife: Mrs. Gussie Langkam
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 8, 1878

8. AGE:

Years	Months	Days	If less than one day
68	3	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business: Factory

FATHER
12. Name: John Langkam
13. Birthplace: ?

MOTHER
14. Maiden name: Sophia Langhurst
15. Birthplace: ?

16. Informant: Hospital Records
Address: Spring Grove State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/47 (month) (day) (year)
Cemetery or crematory: Meadowridge
Location: Woth- Block
18. Funeral director: Clarence F. Hoffmann
Address: 1639 Broadway

19. March 7 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 19 47, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1944 19 to March 4, 19 47 and that I last saw him alive on March 4, 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	10 days
Due to: Generalized arteriosclerotic cardiovascular-renal disease	indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 3-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

★ 02543

Reg. Dist. No. 7-440

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None Mayfield Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GILES E. LEWIS, JR

3.(b) Social Security Number: 577-10-6270

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Maybelle Lewis (Nee Fuller)
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): 4-12-96

8. AGE: Years	Months	Days	If less than one day
50	10	25	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:
FATHER — 12. Name: Giles Lewis
13. Birthplace: New York
MOTHER — 14. Maiden name: Blanche Carrick
15. Birthplace: Maryland
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 10, 1947 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. March 8, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1947, at 8:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1947, to March 7, 1947
and that I last saw him alive on March 7, 1947

	DURATION
Immediate cause of death: CEREBRAL HEMORRHAGE	14 Hrs.
Due to: Hypertension, arterial	Since Jan, 1940
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

P.O.C. Robert M. Cullison
23. SIGNATURE: R.M. CULLISON, M.D. CLIN. DIR. (Official or other)
Address: V.A.H. FORT HOWARD, MD. Date signed: 3-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02544

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 1 day

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 6 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Greys - Ellicott City P.O. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 110 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Elizabeth Lilley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Oliver Lilley

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): September 3, 1873

8. AGE: Years	Months	Days	If less than one day
73	6	3	... hrs. ... min.

9. Birthplace: Oella, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Thomas Robinson

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Martha Wheatley

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-10-47 (month) (day) (year)

Cemetery or crematory: Good Shepherd

Location: Ellicott City, Md.

18. Funeral director: H. Dignhothom

Address: Ellicott City, Md

19. 3-7 (Date rec'd by registrar) 19 47 Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 19 47 at 12:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5 19 46 to March 6 19 47 and that I last saw her alive on March 6 19 47

Immediate cause of death	DURATION
Broncho pneumonia	12 hrs.
Due to: Generalized arteriosclerosis	indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operation: ... Date of op. ...

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 3-6-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

CERTIFICATE OF DEATH

02545 C

Reg. Diat. No. 351

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1029 Beechfield Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clifford B. Luckhardt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret Hynes

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): April 16, 1909

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
37	10	22		

9. Birthplace: Baltimore, Maryland (Town, county, and State)

10. Usual occupation: Stockroom-man

11. Industry or business: Sun Cab Company

FATHER — 12. Name: John Luckhardt

FATHER — 13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Catherine Kartervich

MOTHER — 15. Birthplace: Baltimore

16. Informant: Catonsville-28, Md.

Address: Hospital records

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 13-47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Frederick Rd.

18. Funeral director: John A. Miller

Address: 2334 Jefferson St.

19. 3/11 19 47 R. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 19 47 at 7:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 19 47, to March 10 19 47 and that I last saw him alive on March 10 19 47

Immediate cause of death	DURATION
Therapeutic malaria	1 week
Due to: General paresis	indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 3-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Evidence for the change of age is shown on G 109 4/7/47 + Add'l Birthplace

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02546

CERTIFICATE OF DEATH

46 d

Reg. Dist. No.

1. PLACE OF DEATH:
County: Back River Neck Road
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Middle River, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sabina Majchrzak

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Walter Majchrzak
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Aug 15. 1894
8. AGE: Years 52 Months 5 3/1 Days 6 If less than one day: hrs. min. 10

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

MOTHER
12. Name: Kazdas
13. Birthplace: Poland

FATHER
14. Maiden name: Mikszyna
15. Birthplace: Poland

16. Informant: Walter Majchrzak
Address: Back River Neck Road Middle River

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 6 1947 (month) (day) (year)
Cemetery or crematory: Holy Rosary Cem
Location: Trapido Road
18. Funeral director: Wendel Hoppel
Address: 312 S. Highland Ave.
19. Mar 5 1947 A. W. Jansen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1947 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to March 1 1947 and that I last saw h alive on March 1 1947

	DURATION
Immediate cause of death: Carcinomas of Stomach	
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Baumgardner M. D. or other
Address: 8052 Philadelphia Rd. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Hudson
Fork, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02547 P

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Glen Arm, Baltimore
City or town Baltimore Glen Arm
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Glen Arm, P.O. Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Francis Charles Markley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Annora Markley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1873

8. AGE: Years	Months	Days	If less than one day
74	--	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: John Markley
13. Birthplace: Germany

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs. Mary Lewis Dilworth
Address: Glen Arm, Balto. CO. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/47 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road

19. Mar 10 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6th, 1947 at 330 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4, 1942, to March 6 1947
and that I last saw h... alive on March 6, 1947

Immediate cause of death	DURATION
Congestive Heart Failure	6 Mos.
Due to Arteriosclerotic Heart Disease	5 Yrs.
Due to	
Other conditions Prostatism (Include pregnancy within 3 months of death)	6 Yrs

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Leonard J. Ruck M. D. or other
Address: Fork, Md. Date signed 3/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

P 02548

BC Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years, 7months, 14 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 20 years, 7 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1323 West Baltimore Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John H. Masterman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1868

8. AGE: Years	Months	Days	If less than one day
78	10	11	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Cigarmaker

11. Industry or business: Cigar

FATHER
12. Name: Charles Masterman
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Gavengort
15. Birthplace: Germany

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/47 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Old Frederick road

18. Funeral director: Chas. J. Evans' Son, Inc.
Address: 118 N. Mt. Royal Ave.

19. March 9, 1947 A. W. Frederick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1947, at 4:45 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 1926, to March 15, 1947, and that I last saw him alive on March 15, 1947.

Immediate cause of death	DURATION
Chronic Myocarditis (Coronary disease)	Indef.
Due to: Pulmonary tbc. Bilateral	
Tbc bronchopneumonia &	
Due to: Caseous & fibrous foci	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 3-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02549

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years, 2 months

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 33 years, 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Teresia Mathew (Mateju)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years	Months	Days	If less than one day
67	?	?	hrs. min.

9. Birthplace: Bohemia, Austria (Town, county, and state)

10. Usual occupation: Tailoress

11. Industry or business: Clothing

FATHER 12. Name: Wendelaus Mateju

FATHER 13. Birthplace: Austria

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 4-10-1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 1947, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 1914 to March 28 1947 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Right upper lobar pneumonia	24 hours
Due to: Chronic interstitial nephritis	indefinite
Due to: Coronary sclerotic disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 4-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct name if age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of birth year shown on Film G109-3/24/147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

02550

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 yrs
Hospital, institution, or street address where death occurred:
Mt. De Sales Academy
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Edmondson Ave & Academy Rd
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Sister Mary Martha McCool

3.(b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan. 3, 1867
8. AGE: Years 80 Months 7 Days — If less than one day ..... hrs. ..... min.
9. Birthplace: Co. Donegal Ireland (Town, county, and state)
10. Usual occupation: Religious
11. Industry or business
FATHER 12. Name: Hugh McCool
FATHER 13. Birthplace: Co Donegal, Ireland
MOTHER 14. Maiden name: Annie McMahon
MOTHER 15. Birthplace: Dunmore, Ireland
18. Informant: Mt. De Sales Academy
Address: Catonsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 14 1947 (month) (day) (year)
Cemetery or crematory: Mt. De Sales Cem.
Location: Catonsville Md.
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. 3-13-1947 (Date rec'd by registrar) Harry D. Julian Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1947, at 8:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1947, to March 13 1947
and that I last saw h.. alive on March 9th 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to Tbc	12 Yrs
Due to Acute tubercul-	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Md Date signed 3/13/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

02551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Rockland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Catherine Mc Hadden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William J.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1875

8. AGE:

Years	Months	Days	If less than one day
71	2	18	.....hrs. .....min.

9. Birthplace Gordon, Pa. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business self

FATHER 12. Name George Berger

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden name Katherine Deutschis

MOTHER 15. Birthplace Pa.

16. Informant Jack Higgins

Address Mt. Carmel, Pa.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/12/47 (month) (day) (year)

Cemetery or crematory St. Mary's

Location Mt. Carmel, Pa.

18. Funeral director Wm. Cook Inc.

Address 121 S. St. Paul St. Balto.

19. 3/12 (Date rec'd by registrar) 1947 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11th 1947, to March 12 1947 and that I last saw h.. alive on March 11 1947

Immediate cause of death	DURATION
Coronary thrombosis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

.....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Harry L. McCarty M. D. or other

Address 97 W. Preston St Date signed 3/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-a)

CERTIFICATE OF DEATH

★ 02552

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Ruxton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ruxton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William I. McFadden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Catherine
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 11, 1875

8. AGE: Years	Months	Days	If less than one day
71	7	14	..... hrs. ..... min.

9. Birthplace: Ashland, Pennsylvania
(Town, county, and state)
10. Usual occupation: Mine Foreman
11. Industry or business: Lehigh Valley Company
FATHER 12. Name: John F. McFadden
13. Birthplace: unknown
MOTHER 14. Maiden name: Ellen Mitchell
15. Birthplace: unknown
16. Informant: Mr. Higgins
Address: Mt. Carmel, Pennsylvania
17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/25/47 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Mt. Carmel, Pennsylvania
18. Funeral director: Wm. Cook, Inc.
Address: 1217 St. Paul Street
19. March 25, 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 19 47, at 12 Noon
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21, 1946, to March 25 1947
and that I last saw him alive on Mch 25 1947
Immediate cause of death: Cancer of Larynx. — DURATION: 1 year
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry D McCarty M. D. or other
Address: 37 W Phila Ave Ct Date signed: 3/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-20

2-380-1-10

Maryland State Dept of Health

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02553

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years, 3 mos., 5 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 17 years, 3 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 812 North Linwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Melosik, Adam (Melocik)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary Melocik

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 23, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	16	hrs. min.

9. Birthplace: Austria (Bohemia)
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: Clothing

FATHER 12. Name: Albert Melocik

FATHER 13. Birthplace: Austria

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: Austria

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-14-47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore, Md.

18. Funeral director: Frank Ovach & Son

Address: 900 M. Chester St.,

19. 3/12 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1947 at 12:20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Cardio vascular disease	
Other conditions: sudden death	
Due to: Ingwing	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. M. Kieffer Asst Med Exam'r Balto

M. D. or other

Address: 1010 Leeds Ave Date signed 3-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

02554

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
313 Main Street Reisterstown
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Clara Ellen Hare Mitchell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Charles Mitchell
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 13 1863

8. AGE: Years	Months	Days	If less than one day
83	5	17	..... hrs. ..... min.

9. Birthplace: Beckleysville Md (Town, county, and state)
10. Usual occupation: Retired Housewife
11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mrs Joseph Troyer
Address: 313 Main St Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4 1947 (month) (day) (year)
Cemetery or crematory: All Saints Cemetery
Location: Reisterstown Md

18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. March 3 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: (3) / 2 / 47 19..., at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/45 19... to 3/2/47 19...
and that I last saw h.e.r. alive on (3)/2/47 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days
Due to hypertension	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Reisterstown Md Date signed 3/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

02555

Reg. Dist. No. 30 1

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Hood Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 E. Heath Street
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Sarah E. Moler

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Robert W.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1863

8. AGE:

Years	Months	Days	If less than one day
83	2	6	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William H. Smoot
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Granger
15. Birthplace Maryland

16. Informant R. E. Moler

Address 30 E. Heath St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 6, 1947 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Baltimore, Md.

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul St.

19. March 4 1947 (Date rec'd by registrar) A. W. Yeskey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 2 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1947, to Mar 2 1947 and that I last saw h. alive on Mar 2 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio Vascular Disease	2 days
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE [signature] M. D. or other

Address [signature] Date signed 3-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

02556

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore County
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Opitz Home
Edmonson Ave & Nunnery Lane (Conn
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: (Wash)
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 East Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME HARRY S. MONG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: Real Estate
11. Industry or business: Some.

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Hospital Records, Opitz Rest Home
Address: Edmonson Ave & Nunnery Lane,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24 1947 (month) (day) (year)
Cemetery or crematory:
Location: Hagerstown, Maryland

18. Funeral director: J. Arthur Walters
Address: 254 Carroll St. NW Washington DC

19. 3/xx/47 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 21 1947, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 8 1947, to Mar 21 1947
and that I last saw h... alive on Mar 21 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hours
Due to: Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: 3/21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

CERTIFICATE OF DEATH

02557

Reg. Dist. No. 44

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1105 Stockton Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-II

3.(a) FULL NAME: JAMES W. MONROE

3.(b) Social Security Number: 219-22-0309

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mabel Monroe

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): 5-13-10

8. AGE: Years	Months	Days	If less than one day
36	10	18	..... hrs. ..... min.

9. Birthplace: Essex Cty., Va. (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER — 12. Name: Isaac Monroe

13. Birthplace: Molusk, Va

MOTHER — 14. Maiden name: Lucy Washington

15. Birthplace: Tapaluma, Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/6/47 (month) (day) (year)

Cemetery or crematory: Molusk

Location: Molusk Va

18. Funeral director: Wes. L. Kelson

Address: 1303 Presstman St

19. 4/3 19 47 Alb. Hedrick (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1947, at 8:14 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1947, to March 31, 1947 and that I last saw him alive on March 31, 1947

Immediate cause of death	DURATION
Hemorrhage from peptic ulcer	3 Days
Due to	
Due to	
Other conditions: Carcinoma of liver, primary	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. or other

R.M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H., FORT HOWARD, MD. Date signed: 4-1-47

BALTIMORE CITY HEALTH DEPARTMENT (93-d)

CERTIFICATE OF DEATH

Registered No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore County Jail
(c) Hospital or institution: Dawson

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 02795
(a) State Md. (b) County Timonium
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kenyon Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Leab Orchard Springs Ky.
(Town, county, and state)

10. Usual Occupation Horse Trainer

11. Industry or business

FATHER
12. Name Unk.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant H. H. Furgeson
(b) Address Rockdale Md.

17 (a) Burial (b) Date thereof Apr 4 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Govans Presby
Location York Rd. Balto Md

18 (a) Funeral director Gillespie Armacost
(b) Address 3910 Liberty Hgts ave

19 (a) March 31 47 (b) John D. Cruelle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30- 1947, at 9 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lung abscess.
Myocardial degeneration.
Due to cwdg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-31-47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 02558

Reg. Dist. No. 4-381

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 21, 1947

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since March 21, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

Street No.: Harford County (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Isabelle Morris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Morris

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 24, 1902

8. AGE: Years: 45 | Months: 2 | Days: | If less than one day: hrs. min.

9. Birthplace: Havre de Grace Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Mayfray

FATHER — 13. Birthplace: Havre de Grace Md

MOTHER — 14. Maiden name: Alice Singleton

MOTHER — 15. Birthplace: Havre de Grace Md

16. Informant: Personal History- Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 27 1947 (month) (day) (year)

Cemetery or crematory: Rock Run Cem

Location: Harford Co. Md.

18. Funeral director: H. L. Bailey

Address: Darlington, Md.

19. Mar. 24 1947 (Date rec'd by registrar) Everett Lankford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1947, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1947, to March 24 1947

and that I last saw h.. alive on March 23 1947

Immediate cause of death	DURATION
Emphysema	About 4 months
Due to	
Due to	
Other conditions: Suspected Pulmonary Tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. C. Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 3-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-380-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02559

Reg. Dist. No. 4 1 1

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 minutes
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: a.a.
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: HARRY H. MORRISON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5-13-1886

8. AGE: Years	Months	Days	If less than one day
60	10	18	..... hrs. ..... min.

9. Birthplace: Harford Co., Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Wm. John Morrison
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Hanna Zeiler
15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial & Removal (Burial, cremation, or removal. Which?) Date thereof 4/3/47 (month) (day) (year)
Cemetery or crematory: Mt Vernon
Location: Harford Co. Md.
18. Funeral director: Robert B Harkins
Address: Delta, Pa.

19. 3/31/47 19 (Date rec'd by registrar) J M Learmont Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 19 47, at 2:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 2:40 PM 19 47, to 3/31/47 2:45 P.M. and that I last saw him alive on March 31, 1947 19

Immediate cause of death	DURATION
HEMOPERICARDIUM	Sudden
Due to: Dissecting Aneurysm of Aorta with Rupture	Sudden
Due to:	
Other conditions: Calcification of Aortic Valve with Stenosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Substantiated Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J M Learmont M.D. Deputy Medical Examiner (M. D. or other)
Address: Edgewood Md. Date signed 3/31/47.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

02560

Reg. Dist. No. 381

1. PLACE OF DEATH:
County: Balto County
City or town: Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred: 41 Bloomsbury Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: BALTIMORE
City or town: CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 41 BLOOMSBURY AVE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Espey Morsberger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: EDW. W. MORSBERGER
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): FEB - 4 - 1872

8. AGE: Years	Months	Days	If less than one day
75	1		____ hrs. ____ min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: DOMESTIC
11. Industry or business: HOUSEWIFE

FATHER
12. Name: SAMUEL B ESPEY
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: FRANCES A JOHNSON
15. Birthplace: MARYLAND

16. Informant: FRANCES MORSBERGER
Address: 41 BLOOMSBURY AVE

17. BURIAL (Burial, cremation, or removal, Which?) Date thereof: 3-8-47 (month) (day) (year)
Cemetery or crematory: LOUDON PARK
Location: BALTIMORE - MD.

18. Funeral director: Edw. J. MacNabb
Address: Frederick Road Ave - 28 -

19. 3-7 1947 (Date rec'd by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1947 at 5.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1946, to March 5 1947 and that I last saw h[illegible] alive on March 4 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	5 Min.
Due to: Hypertension Cardio - Vascular Disease	5 yr.
Due to:	
Other conditions: Diabetes Mellitus	23 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Wilson K. Gallagher M.D. (M. D. or other)
Address: Catonsville-28, Md. Date signed: 3-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

02561

Reg. Diat. No. 430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 19-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4415 Kenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest E. Mueller

3.(b) Social Security Number: 215-01-7074

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Frieda Mueller

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 28th, 1886

8. AGE: Years	Months	Days	If less than one day
60	8	11	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Silver Polisher

11. Industry or business: Stieff & Co.

FATHER — 12. Name: E. William Mueller

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Emma Schroeder

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Ernest E. Mueller

Address: 4415 Kenwood Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: March 13th/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: 3310 Taylor Ave.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

19. Mar 24 1947 (Date rec'd by registrar) Mrs. A. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11th 1947, at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1946, to March 11 1947, and that I last saw h alive on March 10 1947

	DURATION
Immediate cause of death	
carcinomas of	3 years
Due to asphyxia	
Due to coronary disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Biopsy - X ray

Primary Malignant Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of Dec 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward Benson M. D. or other

Address: W. Ostend Ave. Date signed: 3/12/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 430

164a

CERTIFICATE OF DEATH

02562

1. PLACE OF DEATH:

(a) County Balto.

(b) City or town Rospeleng. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 7501 Kenleigh Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 6 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Rospeleng. (If outside city or town limits, write RURAL and give town)

(d) Street No. 7501 Kenleigh ave. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Grace Ida Norton.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Fem. | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geo. B. Norton.

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec 22/1893

8. AGE: Years 53 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Jersey City N. J. (Town, county, and state)

10. Usual occupation Wife

11. Industry or business own home

FATHER 12. Name Donald Jensen

13. Birthplace Norway

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Geo. B. Norton

(b) Address 7501 Kenleigh Ave

17 (a) Burial (cremation, or removal) (b) Date thereof 3 15 47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director Carpenter Funeral Home

(b) Address 7401 Belair Rd.

19 (a) Mar. 14, 1947 (Date rec'd by registrar) (b) Mrs. L. Reisinger Registrar

MEDICAL CERTIFICATION

20. Date of death Mar 13 1947, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1947, to Mar 13 1947, and that I last saw him alive on dead, 19____.

Immediate cause of death	Duration
Strangulation due to	
Due to Lodging by neck.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Suicide

(b) Date of occurrence 3/13/47

(c) Where did injury occur? Rospeleng Balto Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? At home in cellar (Specify type of place) While at work?

(e) Means of injury Hanging with rope around neck

23. Signature J. McKenrow M.D. M.D. or other

Address Deputy Medical Examiner Baltimore Md. Date signed 3/17/47

VS: A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

(0256)3 Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Baltimore
City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4108 Taylor Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Margaret D. Nortrup

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Herman H. Nortrup
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4th, 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	1	27		

9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: Frank Winkler
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden name: Catherine Klein
15. Birthplace: Baltimore County, Maryland

16. Informant: Mr. Herman H. Nortrup
Address: 4108 Taylor Avenue

17. burial (Burial, cremation, or removal. Which?) Date thereof: April 4th/47 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Taylor Avenue

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19 April 1 19 47 (Date rec'd by registrar) Mrs. G. L. Responder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31st, 1947 at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1- 1947, to May 31 1947
and that I last saw h~~er~~ alive on May 31 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Arteriosclerosis	1 yr.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas J Kilcher M.D. M. D. or other
Address: 4116 Northern Parkway Date signed: 4/1/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02564 B.

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto.

City or town Maiden Choice Lane & Carroll Ave. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Catonsville

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town Maiden Choice Lane & Carroll Ave. (If outside city or town limits, write RURAL and give nearest town) Catonsville

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ANNIE B. NUSBAUM

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband John W. Nusbaum

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1877

8. AGE: Years	Months	Days	If less than one day
69	5	3	hrs. min.

9. Birthplace Woodsboro, Md. (Town, county, and state)

10. Usual occupation Home

11. Industry or business

FATHER 12. Name Benjamin Williams

13. Birthplace Md.

MOTHER 14. Maiden name Grace Shank

15. Birthplace Md.

16. Informant Mrs. Grace Connelly- Daughter

Address Maiden Choice Lane Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 27, 1947 (month) (day) (year)

Cemetery or ~~Church~~ Holy Cross Cem.

Location A. A. County

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Baltimore 17, Md.

19. 3/26 1947 (Date rec'd by registrar) A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1947, to March 24 1947

and that I last saw her alive on March 24 1947

Immediate cause of death Rheumatic heart disease

DURATION

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. T. Battaglia M.D. M. D. or other

Address 5-814 Belair Rd Date signed 3/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47a

CERTIFICATE OF DEATH

02565

Reg. Diat. No. 570

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Nospital, Institution, or street address where death occurred:
Beaver Dam Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Beaver Dam Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME
JOHN FRANCIS OWENS

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): October — 1865

8. AGE: Years	Months	Days	If less than one day
81	4	—	...hrs. ...min.

9. Birthplace: Cockeysville, Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Blacksmith

FATHER
12. Name: John Owens
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Elwood
15. Birthplace: Ireland

16. Informant: Miss Margaret J. Owens
Address: Beaver Dam Road, Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 7, 1947 (month) (day) (year)
Cemetery or crematory: St. Joseph's Cemetery
Location: Texas, Balto. Co., Maryland
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. March 6 1947 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1947, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9 1946, to March 4 1947 and that I last saw h... alive on March 4 1947

Immediate cause of death	DURATION
Carcinoma Larynx	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth B. Schmidt, M.D. M. D. or other
Address: Cockeysville, Md. Date signed: 3/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-E)

CERTIFICATE OF DEATH

02566

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rockdale (Gwynn Oak P. O.)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: St. James Road

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rockdale (Gwynn Oak P. O.) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: St. James Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Helen Snyder Pape

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Carl L. Pape

6(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July 20, 1900

8. AGE: Years	Months	Days	If less than one day
46	7	14	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home duties

FATHER
12. Name: Henry G. Snyder
13. Birthplace: Maryland

MOTHER
14. Maiden name: M. Criswell
15. Birthplace: Maryland

16. Informant: Carl L. Pape
Address: St. James Rd., Rockdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 - 7 - 47 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md.

18. Funeral director: Frank H. Newell
Address: Pikesville, Md.

19. 3 - 6 - 19 47 (Date rec'd by registrar) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 1947, at 7:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1925 to March 4, 1947, and that I last saw her alive on March 3, 1947.

Immediate cause of death	DURATION
Carcinoma of uterus and ovaries	2 yrs.
Primary in uterus.	
Due to Cause A.	
Due to	
Other conditions: General abdominal metastasis	1 yr

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols M. D. or other

Address: Pikesville 8, Md. Date signed: 3/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

02567

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore.
City or town: Rural near Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 mi West of Hereford.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: T. E. Pearse Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife: Marie C. Pearse
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 1, 1865.

8. AGE:

Years	Months	Days	If less than one day
81	11	29	____ hrs. ____ min.

9. Birthplace: Peterborough, Canada.
(Town, county, and state)
10. Usual occupation: Civil Engineer.
11. Industry or business: Construction.

FATHER
12. Name: Unknown
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Ann Edgecombe
15. Birthplace: Unknown.

16. Informant: T. E. Pearse Jr.
Address: Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 3 1947 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Taylor Ave., Baltimore, Md.

18. Funeral director: Jacob Hartenstein
Address: New Freedom, Pa.

19. Jan 31 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1947, at 6:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 23 1947, to Mar. 30 1947
and that I last saw h[illegible] alive on Mar. 23 1947

Immediate cause of death	DURATION
Cardio-Vascular renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: A. M. Frame M. D. or other
Address: Parkton, Md Date signed: 3/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

02568

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
Golf Course Rd Garrison
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
Street No. Golf Course Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Charles Parmenas Perkins

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Lydia Pritchard Perkins
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): September 28 1875

8. AGE:

Years	Months	Days	If less than one day
71	5	11	...hrs. ...min.

9. Birthplace: Shanklin Isle of Wight England
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: -

FATHER
12. Name: Samuel Perkins
13. Birthplace: England

MOTHER
14. Maiden name: Maria Elizabeth Thomas
15. Birthplace: Shanklin, Isle of Wight, England

16. Informant: Mrs Lydia P Perkins
Address: Garrison Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 12 1947 (month) (day) (year)
Cemetery or crematory: St Thomas Cemetery
Location: Owings Mills, Md

18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. 3-11-47 (Date rec'd by registrar) Dr E P Nichol Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 March 1947, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Jan 1946, to 9 March 1947
and that I last saw him alive on 8 March 1947

Immediate cause of death	DURATION
Carcinoma Lung with metatasis to Brain or skull	2 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: A. F. Ernsker, M.D.
M. D. or other
Address: 22 Hanover Rd Reisterstown, Md Date signed 9 Mar 47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02569

Reg. Dist. No. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: White Marsh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Bird River Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: White Marsh
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bird River Road
(If rural, give LOCATION)
2.(a) If veteran, name war: W

3.(a) FULL NAME: Virginia E. Piercy

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edmond C. Piercy
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 17th 1879

8. AGE: Years	Months	Days	If less than one day
67	2	26	..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business: Self
FATHER 12. Name: Wm. T. Rukert
13. Birthplace: Balto. Md.
MOTHER 14. Maiden name: Mary Sisselberger
15. Birthplace: Balto. Md.
16. Informant: Mrs. Fred. Kreiling
Address: 5603 Everhurst Ave. Mt. Washington
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.
19. Mar 15 1947 (Date rec'd by registrar) A. W. Hudnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1947 at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946, to March 13 1947
and that I last saw h.. alive on March 13 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Arteriosclerotic Cardio Vascular disease	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Maurice Gardner M. D. or other
Address: Balto 6 Md Date signed: 3-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02570

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Balto.

City or town 5610 Carville Ave. Halethorpe (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entirety

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town 5610 Carville Ave. Halethorpe (If outside city or town limits, write RURAL and give nearest town)

Street No. Entirety (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CLARENCE H. PRITCHETT

3.(b) Social Security Number 213-01-3212

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of XXXXX or wife Lillian A. Pritchett

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1885

8. AGE: Years 61 Months 3 Days 20 If less than one day hrs. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual occupation Grocer

11. Industry or business Acme Stores

FATHER 12. Name John M. Pritchett

13. Birthplace Crapo, Md.

MOTHER 14. Maiden name Emily Brannock

15. Birthplace Md.

16. Informant Mrs. Lillian A. Pritchett

Address 5610 Carville Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/26/47 (month) (day) (year)

Cemetery XXXXXXX Loudon Park Cem.

Location Baltimore, Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa Aves. Balto. 17, Md.

19. Mch 27 1947 (Date rec'd by registrar) Geo. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 19 47 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19

and that I last saw h alive on 19

Immediate cause of death Coronary occlusion — DURATION

Due to

Due to Cardiovascular disease

Other conditions sudden death inquiry

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. W. Kieffer Dep. Med. Exam. ... M. D. or other

Address 1010 Leedham Date signed 3-25-47

(M) (I) X

1-35

02571

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49a)

CERTIFICATE OF DEATH

Reg. Dist. No. 430

1. PLACE OF DEATH:
County: Baltimore
City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
3800 Putty Hill Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alberta B. Raab

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John A. Raab
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15th, 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	11	16		

9. Birthplace: Baltimore County, Md. (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: John Harple
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Schaffer
15. Birthplace: Pa.

16. Informant: Mrs. Benjamin J. Schrenker
Address: 3800 Putty Hill Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: March 6.1947 (month) (day) (year)

Cemetery or crematory: St. Josephs
Location: Belair Road

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19. Mar. 4 (Date rec'd by registrar) 19 47 Mrs. G. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3rd 19 47 at 1:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1946, to March 3rd 1947 and that I last saw h[illegible] alive on March 2nd 1947

Immediate cause of death	DURATION
Carcinoma,	6 mos.
Due to Primary cancer of Intestines to Liver,	
Due to Other organs of abdomen,	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of left Colon with metastasis to Liver Date of op. 10/25/46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edward Parson M. D. or other
Address: 1W. Oella Ave Date signed 3/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 02572 — Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 48 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: HENRY C. RISLEY

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married - Separated

6.(b) Name of husband or wife: Mrs. Agnes Risley
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): December 28, 1892

8. AGE: Years	Months	Days	If less than one day
54	2	26	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Charles Risley
13. Birthplace: Germany

MOTHER
14. Maiden name: Frances Larkes
15. Birthplace: Germany

16. Informant: Clinical Records Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 26, 1947 (month) (day) (year)
Cemetery or crematory: Baltimore National Cem.
Location: Baltimore, Maryland
18. Funeral director: Ellsworth Armacost
Address: 3911 Liberty Heights Ave., Balto. Md.

19. 3/26 (Date rec'd by registrar) 19 47 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 19 47, at 10:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4, 1947, to March 24, 19 47 and that I last saw him alive on March 24, 19 47

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	8 yrs.
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Substantiated Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison, M.D.
R. M. CULLISON, M.D., CLIN. DIRECTOR
Address: VAH, Fort Howard, Md. Date signed: 3/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02573

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Baltimore

City or town: Colonial Village, Pikesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Colonial Village, Pikesville (If outside city or town limits, write RURAL and give nearest town)

Street No. 7113 Plymouth Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen Alonzo Rohr

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Clyde C. Rohr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 28, 1876

8. AGE: Years	Months	Days	If less than one day
70	9	19	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Alonzo Snyder

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Mary J. Adams

15. Birthplace: Baltimore, Md.

16. Informant: Miss Helen C. Rohr

Address: 7113 Plymouth Rd. Pikesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-22-47 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore, Md.

18. Funeral director: G Howard Strong

Address: 3207 W. North Ave.

19. 3/20 (Date rec'd by registrar) 19 47 H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1947 at 2.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20th 1946 to March 19 1947 and that I last saw h.e.r. alive on March 18 1947

Immediate cause of death	DURATION
1) Arterio-Sclerotic Heart Disease	5 yrs.
Due to	
Due to	
Other conditions 1)	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other

Address: 4106 Liberty Hts. Date signed 3/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46M)

CERTIFICATE OF DEATH

02574

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County Md.
City or town Randalstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred:
Augsburg Home
How long in hospital or Institution? 7 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Randalstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Campfield Rd
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Louise Ruehr

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age .....years

7. Birth date of deceased (mo., day, yr.) May 17. 1861

8. AGE: Years 85 | Months 10 | Days 1 | If less than one day .....hrs. .....min.

9. Birthplace Phila Pa.
(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name C. Ruehr
13. Birthplace Unknown

MOTHER 14. Maiden name Caroline Haselman
15. Birthplace Unknown

16. Informant Records
Address Augsburg Home Campfield Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory Northwood Cem
Location Phila Pa

18. Funeral director L. HECKMAN & SON
Address 6067 HARFORD Rd.

19. March 9 1947 C. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5th. 1947, to March 18 1947
and that I last saw h.e.r alive on March 18. 1947

Immediate cause of death	DURATION
a) Carcinoma of Entero-Intestinal Tract.	6 mos.
Due to	
Due to	
Other conditions 1) Entero-Intestinal Heart Disease (Include pregnancy within 3 months of death)	5 yrs. ?

Major findings of operation .....
Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Earl L. Chambers M. D. or other
Address 410 E. Liberty Hts. Date signed 3/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02575 ★

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 38 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1918 Park Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CHARLES W. RUSSELL

3.(b) Social Security Number: 149-05-4032

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ////// Mae Bruce Russell
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): 6-20-1887

8. AGE: Years	Months	Days	If less than one day
59	8	16	..... hrs. ..... min.

9. Birthplace: Viverton, N. J.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:
FATHER 12. Name: Francis Russell
13. Birthplace: Wilmington Delaware
MOTHER 14. Maiden name: Irene Cole
15. Birthplace: Tomaqua, Pennsylvania
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 8-47 (month) (day) (year)
Cemetery or crematory:
Location: Atlantic City New Jersey
18. Funeral director: Ellsworth Brumcoat
Address: 3911 Liberty Heights Ave
19. March 7 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1947 at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27, 1947 to March 5, 1947 and that I last saw him alive on March 5, 1947

Immediate cause of death	DURATION
Multiple infarction of kidneys with uremia and lobular pneumonia, bilateral Cause, Unknown	2 Days
Due to:	
Other Cond: Colloid cancer of the rectum with metastasis to the liver	4 Mos.
Colostomy: Insertion of rubber tube in small intestine; leakage about tube; peritonitis	2 days.

(Include pregnancy within 3 months of death)
Major Number of operations: Operations: 2-10-47 Colostomy in sigmoid portion of the colon. 2-26-47 (1) Ileostomy (2) Closure of dehiscence of abdominal wound. (3) Bronchoscopy
Date of op.
Autopsy results: Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

97C
23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
Address: V.A. Ft. Howard, Md. Date signed: 3-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-2)

CERTIFICATE OF DEATH

12576

Reg. Dist. No. 4K

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 27 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2608 Violet Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: NATHAN F. SANDLER

3.(b) Social Security Number: 212-07-6076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Kate Sandler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-20-95

8. AGE:

Years	Months	Days	If less than one day
51	6	6	hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER

12. Name: Morris Sandler

13. Birthplace: Russia

MOTHER

14. Maiden name: Sarah Buckinsky

15. Birthplace: ?

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-28-47 (month) (day) (year)

Cemetery or crematory: Brae Israel

Location: Loyalton Ave.

18. Funeral director: Jack Levin Inc.

Address: 1438 E. Baltimore St.

19. 3/26 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 19 47 at 10:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 19 47, to March 26, 19 47 and that I last saw h im alive on March 26, 19 47

	DURATION
Immediate cause of death: METASTATIC MELANOSARCOMA OF LIVER	3 months
Due to: MELANOSARCOMA, LEFT EYE	4 years
Due to: ENUCLEATION, LEFT EYE, 1944	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

ROBERT M. CULLISON, M.D. M. D. or other

Address: FORT HOWARD, MARYLAND Date signed: 3/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

62577

Reg. Dist. No. 310

1. PLACE OF DEATH:

County: Baltimore

City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, Institution, or street address where death occurred:
8208 Liberty Road

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8208 Liberty Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah J. Schafer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph H. Schafer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 31, 1869

8. AGE: Years	Months	Days	If less than one day
77	6	4	..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Henry V. Keller

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Adaline Barker

MOTHER — 15. Birthplace: Maryland

16. Informant: Mr. George Dettner

Address: 8208 Liberty Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 6, 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Woodlawn, Md.

18. Funeral director: E. Miller Lamoreux

Address: 4510 Liberty Heights Ave.

19 Mar 4 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 47 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 19 47, to Mar 7 19 47 and that I last saw h.. alive on Mar 3 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Gall Bladder Infection	30 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. C. Smith M. D. or other

Address 4209 Liberty Hts. Date signed Mar 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

02578

Reg. Dist. No. 441

1. PLACE OF DEATH:

County Balto.

City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, institution, or street address where death occurred:
Chesaco Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. Chesaco Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CHARLES SCHATZSCHNEIDER

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Margaret V. Schatzschneider

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30th, 1859

8. AGE: Years	Months	Days	If less than one day
87	9	29	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Truck Farm

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mr. George Bitter

Address 121 N. Highland Ave., Balto. Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Mar. 31, 1947 (month) (day) (year)

Cemetery or crematory Zion Lutheran Cemetery

Location Stemmers Run, Md.

18. Funeral director Lanahan Funeral Home

Address 7401 Belair Road

19. 3/31-47 (Date rec'd by registrar) 19 ..... John S. Comeldy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th, 1947, at 2:10A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1947, to March 29 1947 and that I last saw h. alive on March 29 1947

Immediate cause of death	DURATION
Cerebral apoplexy	2 days
Due to Arterio sclerotic Cardio Vascular disease	
Due to	
Other conditions Urinary Retention Cord Bladder	4 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo M. Baumgardner M. D. or other

Address Balto 6 Md Date signed 3-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-440- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02579

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Harbor View
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7039 Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Conrad Schiefer

3.(b) Social Security Number: 216-01-0140

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary Schiefer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 7 1883
8. AGE: Years: 63 Months: 5 Days: 4 If less than one day: hrs. min.
8. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Tank & Tower erector
11. Industry or business:
FATHER 12. Name: Schiefer
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Mrs. Mary Schiefer
Address: 7039 Eastern Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 12 47 (month) (day) (year)
Cemetery or crematory: Baltimore Cem.
Location: Baltimore
18. Funeral director: Philip Herwig Sons
Address: 2024 Orleans St.
19. 3/13 19 47 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 11 19 47 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1947 to March 11 1947 and that I last saw h.... alive on March 11 1947.

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.:
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James F. White, M. D.
M. D. or other
Address: 7601 Eastern Ave, Balto 24, Md. Date signed: 3/13/47

Dr. White
7601 Eastern Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10
02580
RC
Reg. Dist. No. 9

1. PLACE OF DEATH:
County Baltimore
City or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place at death? Since August 21, 1946
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since August 21, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1814 W Lemmon St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Agnes Loretta Schultheis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Geo. F. Schultheis
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 7, 1916

8. AGE: Years 30 | Months 4 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Little
13. Birthplace Baltimore

MOTHER
14. Maiden name Mary Rockwood
15. Birthplace Baltimore Md

16. Informant Personal History- Hospital Records
Address Eudowood Sanatorium, Towson 4, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar 8 '47 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Baltimore, Md

18. Funeral director F. B. Wisner & Son
Address 1300 Eutaw Place

19. Mar 5 1947 (Date rec'd by registrar) C. W. Fedder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1947, at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 1946, to Mar 5, 1947
and that I last saw h alive on March 3 1947

Immediate cause of death Pulmonary Tuberculosis — DURATION: Since July 1941

Due to —

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W A Bridges M. D. or other
Address Towson, 4, Maryland Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

126 BC 02581 Reg. Diat. No. 44

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VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Yrs. 7 Mos. 14 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 2 Yrs. 7 Mos. 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3303 Carlisle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I & SAW

3.(a) FULL NAME: OSCAR T. SCHULTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 9-28-1877

8. AGE: Years	Months	Days	If less than one day
69	5	9	..... hrs. ..... min.

9. Birthplace: Vernon, Ind.
(Town, county, and state)

10. Usual occupation: Doctor-Pathologist

11. Industry or business:

FATHER
12. Name: Oscar T. Schultz
13. Birthplace: Germany

MOTHER
14. Maiden name: Louise Pfeffer
15. Birthplace: Kentucky

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof (month) March (day) 11 (year) 47

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: Ellsworth Armacost

Address: 3911 Liberty Heights Ave

19. (Date rec'd by registrar) 3/10 19 47 Registrar: Dodd Hedrick Dep

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 19 47, at 11:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1944, to March 7, 1947 and that I last saw him alive on March 7, 1947

Immediate cause of death	DURATION
Abscesses of liver, miliary -	1 week
Due to Cholangitis, acute	1 week
Due to	
Other conditions Generalized arterio-sclerosis	15 years
(Include pregnancy within 3 months of death) Cholelithiasis	5 years

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. E. Pugh M.D. M. D. or other

Address: Ft Howard Md Date signed: March 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02582 480

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Hotel Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Hotel Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sister Mary Amabilis Schwartz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1870

8. AGE:

Years	Months	Days	If less than one day
77	2	23	..... hrs. ..... min.

9. Birthplace: Rochester N. Y. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business

FATHER

12. Name: Samuel Schwartz

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Mary Ann Uhl

15. Birthplace: Rochester, N. Y.

16. Informant: Sr. Mary Clara

Address: Hotel Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 12/47 (month) (day) (year)

Cemetery or crematory: Hotel Cliff

Location: Glen Arm

18. Funeral director: Geo M. Frank & Son

Address: 811 N Howard St

19. Mar 13 1947 (Date rec'd by registrar) Walter M. Hammond By M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 19 47 at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 19 44, to March 9 19 47 and that I last saw h.er alive on Feb 26 19 47

Immediate cause of death	DURATION
Coronary Occlusion	3 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Towson, Md Date signed Mar 9 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

02583

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH
County: Baltimore -22-
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4½ yrs.
Hospital, institution, or street address, where death occurred:
7217 Glenglen Court.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Sparrows Point #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Amanda Wharton Scott.

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: William Steuart Scott. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 9. 1867.

8. AGE:

Years	Months	Days	If less than one day
79	5	14	hrs. min.

9. Birthplace: Philadelphia Pa.
(Town, county, and state)
10. Usual occupation: Housework.
11. Industry or business: at home.

FATHER
12. Name: Peter S. Wharton
13. Birthplace: Philadelphia.

MOTHER
14. Maiden name: Eliza Streeter
15. Birthplace: Philadelphia.

16. Informant: Marion Scott Smith
Address: 1608 Locust St. Philadelphia

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 28/47 (month) (day) (year)
Cemetery or crematory: Unionville Cem
Location: Unionville Pa
18. Funeral director: Weld Funeral Home
Address: 2008 Orleans St

19. 3/26/47 (Date rec'd by registrar) A. W. Kelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 23. 1947, at 1-25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30. 1946, to Mar. 23 1947
and that I last saw h[illegible] alive on Mar. 19. 1947.

Immediate cause of death	DURATION
Gastric.	
adenocarcinoma	
Due to associated with:	
arteriosclerotic	
Due to cardio vascular disease	A.
Other conditions Kyphosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Sodini M.D. M. D. or other
Address: Sparrows Point. Md. Date signed: 3/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

02584

Reg. Dist. No. 401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Balto Co
City or town: Glen Arm
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto Co
City or town: Glen Arm
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ~~Her~~ Nola May Shackelford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Harry Shackelford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 - 1902

8. AGE: Years	Months	Days	If less than one day
44			..... hrs. ..... min.

9. Birthplace: Forest Hill, Md (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Wm T Monks
13. Birthplace: Md

MOTHER
14. Maiden name: Mary Lingan
15. Birthplace: Md

16. Informant: Harry Shackelford.
Address: Glen Arm, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8/47 (month) (day) (year)
Cemetery or crematory: Mt. Tabor
Location: Near Bel Air, Md
18. Funeral director: Deems Foster
Address: Bel Air Md

19. Mar 6 1947 (Date rec'd by registrar) C. E. Arthurs Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 5 1947, at 11 18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943, to Mar. 5 1947
and that I last saw her alive on Mar. 5 1947

Immediate cause of death	DURATION
Carcinoma of breast with metastases to brain.	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of breast
Date of op. 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George G. Merrill M.D.
M. D. or other
Address: Baldwin, Md. Date signed Mar. 5, 1947

1-25

2-400- 1-10

02585

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46g

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 9 months, 17 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 4 years, 9 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 1234 East Eager Street
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie Shaver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1892

8. AGE: Years	Months	Days	If less than one day
54	8	19	hrs. min.

9. Birthplace: Parkton, Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Joseph Shaver
13. Birthplace: ?

MOTHER
14. Maiden name: Sara Ball Dorsey
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 4-10-1947 (Date rec'd by registrar) Harry H. Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1947 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1942, to March 26 1947 and that I last saw her alive on March 26 1947

Immediate cause of death	DURATION
Carcinomatosis, lymph glands, pancreas, portal system, liver and	
Due to lungs --	indefinite
Adhesive pericarditis	"
Due to Anurism of the heart	"
Broncho pneumonia, right upper	
Other conditions lobe --	3 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed 3-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

CERTIFICATE OF DEATH

02586

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2204 Cedley St.,

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: EMORY M. SKIPPER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Skipper

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4-4-97

8. AGE:

Years	Months	Days	If less than one day
49	11	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Guard

11. Industry or business

FATHER

12. Name: Not Known

13. Birthplace: "

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/47 (month) (day) (year)

Cemetery or crematory: Western Cem.

Location: Baltimore City.

18. Funeral director: C. Vernon Lemmon

Address: 4611 Park Heights.

19. 3/27 (Date rec'd by registrar) 1947 H. B. Fehrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1947 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1947 to March 24, 1947 and that I last saw him alive on March 24, 1947

Immediate cause of death	DURATION
Ulcer, Duodenal bleeding	Approx., 3 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. or other

R.M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H. Ft. Howard, Md. Date signed: 3-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

02587

Reg. Dist. No. 430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7206 Linden Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Albert M. Smith

3.(b) Social Security Number: 215-01-2887

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Edna E. Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17th, 1889

8. AGE: Years	Months	Days	If less than one day
57	7	1	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Steam Fitter

11. Industry or business: Lloyd E. Mitchell

FATHER
12. Name: Isaac H. Smith
13. Birthplace: Dingmans Ferry, Pa.

MOTHER
14. Maiden name: Mary E. Middaugh
15. Birthplace: Dingmans Ferry, Pa.

16. Informant: Mrs. Robert H. Wells
Address: 7206 Linden Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: March 22nd/47 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: 7225 Eastern Ave.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

19. March 20 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18th 19 47, at 6 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 4, 19 47, to Mar 18 19 47 and that I last saw h... alive on Mar 17 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	14 days
Due to: Arteriosclerosis	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A Lee Mitchell M.D.
M. D. or other

Address: 4116 Northern Parkway Date signed: 3/19/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02588

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Belair Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George M. Smith

3.(b) Social Security Number: 218-01-3574

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Barbara E. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 8th, 1883

8. AGE: Years	Months	Days	If less than one day
63	3	15	..... hrs. ..... min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business

FATHER 12. Name: James Smith

13. Birthplace

MOTHER 14. Maiden name: Catherine Pfeiffer

15. Birthplace: Baltimore County, Md.

16. Informant: Mrs. George M. Smith

Address: Belair Road, Fullerton P.O.

17. burial (Burial, cremation, or removal. Which?) Date thereof March 26th/47 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Belair Road

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

19. 3/25/47 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23rd 19 47, at 3:55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/30 19 47, to 3/23 19 47 and that I last saw h. /.. alive on 3/22 19 47

Immediate cause of death	DURATION
TERMINAL PNEUMONIA	4 days
Due to: LEFT HEMIPLEGIA	2 MOS
Due to: CEREBRAL ARTERIOSCLEROSIS	6 MOS
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John H. Hirschfeld M. D. or other

Address: 6919 Harford Rd Date signed 3/24/47

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02589

Reg. Dist. No. 430

1. PLACE OF DEATH:

County: Balto.

City or town: Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: North River Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Chase (If outside city or town limits, write RURAL and give nearest town)

Street No.: North River Drive (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Joseph G. Smith

3.(b) Social Security Number: 217-16-8970

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Anna M. Smith

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 20th 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	9	20		

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Mrs. Jas. Schwarz

Address: Balto. 20 R.F.D. 14 #187

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 15 47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto. Md.

16. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Rd.

19. Mar 14 1947 (Date rec'd by registrar) Mrs. G. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12th 1947, at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1947, to Mar. 7 1947 and that I last saw h.i.m. alive on Mar. 1947

Immediate cause of death	DURATION
Arteriosclerosis generalized	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. Battaglia M.D. M. D. or other

Address: 5829 Belair Rd. Date signed: 3/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Battaglia

1-35

02590 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 5 months, 4 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 4 years, 5 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 539 N. Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY ELIZABETH SNYDER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife: George W. Snyder
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): August 11, 1865

8. AGE:

Years	Months	Days	If less than one day
81	7	2	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: George Roberts
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Catherine O'Brien
15. Birthplace: Ireland

16. Informant: Hospital Records
Address: Catonsville 28, Maryland

17. Burial — Date thereof 3/15/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Old Frederick road

18. Funeral director: Chas. J. Evans & Son, Inc.
Address: 118 N. Mt. Royal Ave

19. 3/17 19 47 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 19 47 at 3:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 19 42 to March 13 19 47 and that I last saw her alive on March 13 19 47

Immediate cause of death	DURATION
Cardiac Failure	3 hours
Due to Broncho-pneumonia	11 days
Due to Generalized arteriosclerosis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Isadore Tuerk
23. SIGNATURE: Isadore Tuerk, M. D.
M. D. or other
Address: Catonsville 28, Md. Date signed: 3/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

02591

Reg. Dist. No. 400

1. PLACE OF DEATH:

County: Baltimore

City or town: Glenarm, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:
Schroeder Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glenarm, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Schroeder Ave.
(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elmer J. Spamer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Bettie May Spamer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 2nd, 1862

8. AGE: Years	Months	Days	If less than one day
84	5	19	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Truck Farmer

11. Industry or business

FATHER
12. Name: Ludwig Spamer
13. Birthplace: Germany

MOTHER
14. Maiden name: Julia Martin
15. Birthplace: Russia

16. Informant: Mrs. Harry C. Sadler
Address: Schroeder Ave. Glenarm P.O.

17. burial (Burial, cremation, or removal. Which?) Date thereof March 23rd/47 (month) (day) (year)

Cemetery or crematory: Spamer Burying Grounds

Location: Balto. Co. Md.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

3/22/47 (Date rec'd by registrar) 19 W. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20th, 1947 19..... at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 19 46 to March 19 19 47 and that I last saw h— alive on March 19 19 47

Immediate cause of death	DURATION
Uraemia	6 wks
Due to Carcinoma of neck and Tuberculosis	3 yrs
Due to Primary in skin, nape of neck, starting as a mole. Cured.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clifford T. Leatherwood M. D. or other

Address: Fork, Md. Date signed 3/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 0232

P.

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 126 Sherwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Caroline (Carrie) Lushine Stanley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ James B. Stanley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1860

8. AGE: Years	Months	Days	If less than one day
86	10	4	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace:
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Mrs Ava E. Plimack
Address 126 Sherwood Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-7-47 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore, Md.
18. Funeral director: Lowry Byers
Address 5905 Park Heights Ave
19. 3/6 19 47 D. W. Roderick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1947 at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Mar 4 1947
and that I last saw h~~e~~ alive on Mar 4 1947

Immediate cause of death	DURATION
Chronic Myocarditis	5 years
Due to Bronchopneumonia	
Due to Senility	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Edward J. Bruce M. D. or other
Address 5276 Park Heights Ave Date signed Mch 6 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

3374

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred: 602 North Bend Rd.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 602 North Bend Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: Catherine D. Stenner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Divorced

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	10	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: William Airey
13. Birthplace: Md.

MOTHER
14. Maiden name: Catherine Carle
15. Birthplace: Md.

16. Informant: Mrs. Annie Ball
Address: 602 North Bend Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/31/47. (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Rd.
18. Funeral director: Harry H. Whitelaw
Address: 4101 Edmondson Ave.

19. 3-29 1947 (Date rec'd by registrar) A. W. Kellogg M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947, at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1946, to March 27 1947 and that I last saw h.. alive on March 11 1947

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Leo J. Gaver M.D.
M. D. or other
Address: Medallion Village Date signed: 3/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02593

Reg. Dist. No. 381

8

1. PLACE OF DEATH:
County Balto,
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs
Hospital, Institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Balto,
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 E. Chesapeake Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carroll Stehn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife Clara Stehn
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18th 1869

8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace Old Fort N. C. (Town, county, and state)

10. Usual occupation Landscaper

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Bessie Williams
Address 414 Virginia Ave Towson Md.

17. Burial Date thereof March 4th 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pleasant Rest
Location Towson Md, Balto Co.

18. Funeral director Byron Manor & Wright
Address 721 Cathedral St Balto 2, Md.

19. Mar. 4 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 1 1947, at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 2 1944 to Mar. 1 1947 and that I last saw h— alive on Mar. 1 — 1947

Immediate cause of death	DURATION
Cardio - Renal Desease	
Due to	24 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE Louis A. Johnson M. D. or other
Address 2829 Guilford Ave Date signed Mar. 3 1947

1-25 2-380 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, (22-a)

CERTIFICATE OF DEATH

Item 3 Film G398 3/20/68 kk

BC 02594
Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Howard, Maryland
How long in hospital or Institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1013 Whatcoat St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-II

3.(a) FULL NAME: ~~WILLIAM A STEVENSON~~ William Sampson Brook Stevenson

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs. Mabel Stevenson
6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): 11/7/42

8. AGE: Years	Months	Days	If less than one day
24	4	13	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:

FATHER
12. Name: Not known
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: 3/25/47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cem.
Location: Baltimore, Md.

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Balto., Md.

19. March 24 19 47 A. H. Hodnett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1947, 11:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1947, to March 20, 1947 and that I last saw him alive on March 20, 1947

Immediate cause of death	DURATION
Miliary Tuberculosis	6 Wks.
Due to:	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M.D.R. or other
Address: V.A.H. FT. HOWARD, MD. Date signed: 3-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of age and addition of birth date is shown on G 109 3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02595

Reg. Diat. No.....

1. PLACE OF DEATH:
County BALTIMORE
City or town WOODLAWN, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
2151 LORRAINE AVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County BALTIMORE
City or town WOODLAWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2151 LORRAINE AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOHN EDWARD STEWART, SR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband or wife LOUISE (WHEELER)
6.(c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 12 1865

8. AGE: Years	Months	Days	If less than one day
82	8 11		hrs. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual occupation CARPENTER.
11. Industry or business

FATHER
12. Name THOMAS W. STEWART
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden name UNKNOWN
15. Birthplace "

16. Informant JOHN E STEWART, JR.
Address 2151 LORRAINE AVE.

17. BURIAL Date thereof 3 17 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory LOUDON PARK
Location FREDERICK RD.
18. Funeral director JOHN F DENNY, INC.
Address 715 LIGHT ST.

19. MAR 15 19 47 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 14, 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1-47 19 47 to 3-14 19 47
and that I last saw h. alive on 3-14 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Generalized Arteriosclerosis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE Thos J Abbott M. D. or other
Address 4509 Liberty Heights Date signed 3-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 02596

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, Institution, or street address where death occurred: 113 Ingleside Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 113 Ingleside Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Minerva R. Stultz

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: David M. Stultz
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1873

8. AGE:

Years	Months	Days	If less than one day
74	1	7	..... hrs. ..... min.

9. Birthplace: Bunker Hill W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Worthington J. Stultz
Address: 113 Ingleside Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Ave. Balto. Md.

18. Funeral director: Easton Sons
Address: Ellicott City, Md.

19. 3-12 (Date rec'd by registrar) 1947 Harry W. Griffis Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1947, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1946, to March 11 1947
and that I last saw h.. alive on March 10 1947

Immediate cause of death	DURATION
(a) Diabetes Mellitus	15 yrs.
Myocardial Degeneration	3 yr.
Due to (b) (Arterio-Sclerosis)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: I. Lloyd Johnson M. D. or other
Address: Catonsville, Md. Date signed: 3/12/47

1 - 55

02597

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rodgers Forge Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rodgers Forge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Murdock Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: AGNES G. SWEENEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas E. Sweeney

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): July 24, 1870

8. AGE: Years	Months	Days	If less than one day
76	7	18	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Patrick Murray
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Feeley
15. Birthplace: Ireland

16. Informant: Miss Marie A. Sweeney
Address: 310 Murdock Rd. Rodgers Forge

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/47 (mooth) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore, Maryland

18. Funeral director: H. W. Mears and Son

Address: 805 Walnut Street.

19. 3/14/47 (Date rec'd by registrar) A. L. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 March 1947 at 9:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1947 to March 12 1947 and that I last saw h. alive on March 12 1947

Immediate cause of death	DURATION
Cerebral vascular accident - Hemorrhage	6 days
Due to: Arteriosclerotic Hypertensive disease.	10 yrs.
Due to:	
Other conditions: Diabetes Mellitus	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. H. Kammer, Jr. M. D. or other

Address: 501 S Meridan Ave. Date signed: 13 Mar. 47

02598

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Rachel Anna Talbert

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Horace A Talbert

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Feb. 29, 1872

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	—	28		

9. Birthplace: Butler, Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Levi Naylor
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Rachel Russell
15. Birthplace: Balto. Co. Md.

16. Informant: Horace A Talbert
Address: Sparks, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30-1947 (month) (day) (year)

Cemetery or crematory: Black Rock

Location: Butler, Balto. Co. Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 3-29 19 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 19 47, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15- 19 45, to 3/28 19 47

and that I last saw h.. alive on 3/28 19 47

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to: Chronic Nephritis	5 yrs.
Due to:	
Other conditions: Arthritis Deformans	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M. D.
M. D. or other

Address: Cockeysville Md. Date signed 3/29/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02599

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto
City or town: Edgemere
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 2612 Sparrows Point Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Edgemere
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2612 Sparrows Point Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W.

3.(a) FULL NAME: James Edward Talley

3.(b) Social Security Number: 213-07-1651

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Talley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 19th 1887

8. AGE: Years	Months	Days	If less than one day
59	11	11	..... hrs. ..... min.

9. Birthplace: Louisa Co. Va.
(Town, county, and state)
10. Usual occupation: Steel Worker
11. Industry or business: Bethlehem Steel Co

FATHER
12. Name: William O. Talley
13. Birthplace: Louisa Co. Va.

MOTHER
14. Maiden name: Levinia Haynes
15. Birthplace: Louisa Co. Va.

16. Informant: Elizabeth Talley (Wife)
Address: 2612 Sparrows Pt. Rd. Edgemere Md.

17. Burial (Burial, cremation, or Removal. Which?) Date thereof 4/3/47 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Baltimore Co. Md.

18. Funeral director: William Cook Inc.
Address: 127 E. Paul St.

19. March 31 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 19 47 at 2 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 19 47 to March 30 19 47 and that I last saw h.. alive on March 30 19 47

Immediate cause of death	DURATION
Arteriosclerotic heart disease	7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. B. Landes M.D.
M. D. or other
Address: 5200 Dist. Sp. Fld. Date signed: 3.30.47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

James E. Fallon

02600

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
1902 Jackson Road
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1902 Jackson Road
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: Wilhelmina L. Thiele

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Fred J. Thiele
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 11, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	25	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Frederick Hoffmeir
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mr. Fred Thiele
Address: 1902 Jackson Rd., Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 8, 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn, Md.
18. Funeral director: Miller Lamoreau
Address: 4510 Liberty Heights Ave.
19. Mar 8 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1947 at 6.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw her alive on ..... 19.....

Immediate cause of death	DURATION
Sub-dural Hemorrhage	6 hrs.
Due to: Fell down Stairs	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3/5/47
Where did injury occur? Dundalk - Balto. Md.
(City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) Home
Means of injury: Fell down Stairs Injured at work? No

23. SIGNATURE: M. Bowers M.D.
M. D. or other
Address: 3 Kinship Rd., Dundalk Date signed: 3/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02601

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 W. York Road

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: HENRY THOMAS

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-22-85

8. AGE: Years	Months	Days	If less than one day
61	2	25	hrs. min.

9. Birthplace: Danville, Va. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: John Thomas

13. Birthplace: Danville, Va.

MOTHER — 14. Maiden name: Alice

15. Birthplace: Danville, Va.

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/47 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore Md

18. Funeral director: Isaiah L. Brown & Son

Address: 108 W Montgomery St

19. March 19 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1947, at 5:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 1947, to March 17, 1947 and that I last saw him alive on March 17, 1947

Immediate cause of death	DURATION
Disease of the Heart	
Cause: Coronary Arteriosclerosis	6 Mos.
Structural Lesion: Myocardial damage	
Due to: Manif: Myocardial Insufficiency	
Due to:	
Due to:	
Other conditions: Syphilis, late, latent	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR. M.D. or Other

Address: V.A. FORT HOWARD, MD. Date signed: 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the addition of year of birth is shown on G 109 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02602

93d ★

Reg. Dist. No. 441

1. PLACE OF DEATH:
County Balto.
City or town Middle River.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Kingston Pk. Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give resideoce of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. Kingston Pk. Road.
(If roral, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Margaret O Thompson.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Singie, married, widowed, or divorced
F	W	married.

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 15 1877

8. AGE: Years	Months	Days	If less than one day
69			..... hrs. ..... min.

9. Birthplace N. E. Maryland.
(Town, county, and state)
10. Usual occupation at Home.
11. Industry or business
FATHER 12. Name Nathan Faulkner.
13. Birthplace Md.
MOTHER 14. Maiden name Susan Melvin.
15. Birthplace Md.
16. Informant Mrs. Phoebe Weatherstein
Address Box 105 Kingston Pk. Rd.
17. Removal. Date thereof 3/23/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Soberbrook.
Location Delaware.
18. Funeral director Lee Nichols
Address 2107 N James St.
19. 3/23/47 19.....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 47, at VA. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 19 47 to March 20 19 47 and that I last saw h...er alive on March 19 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	10 days
Due to Arterio sclerotic Heart disease	Yrs
Due to Hypertension	Yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatioos
Date of op.
Aotopsy results
PHYSICIAN: Please ooderline the caose to which death shoold he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (Coonty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas B Quigley M. D.
M. D. or other
Address 8.5 Eastern Ave Baltimore Md Date signed 3/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1

2-25

2-440- 2-10

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

3375

Reg. Diat. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills P.O.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills P.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No. McDonough Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry G. Tillman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife Sallie Tillman

6.(c) If alive, give age ..... years

Deceased

7. Birth date of deceased (mo., day, yr.) July 29 - 1865

8. AGE:

Years	Months	Days	If less than one day
81	7	24	..... hrs. ..... min.

9. Birthplace Baltimore County, Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name John Tillman

13. Birthplace Balto. Co. Md

MOTHER

14. Maiden name Mary Eckman

15. Birthplace Balto. Co. Md

16. Informant Mrs John Tillman

Address McDonough Rd. Owings Mills P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26-47 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Randallstown Md

18. Funeral director Frank F. Newell

Address Pikesville Md

19. 3/25/47 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 20, 1947, to Mar. 24, 1947

and that I last saw [illegible] alive on Mar. 24, 1947

Immediate cause of death	DURATION
Cardio Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 3/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02603

Reg. Diat. No. 425

1. PLACE OF DEATH:
County: Baltimore
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, Institution, or street address where death occurred: 4205 Fordham Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4205 Fordham Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Louis Charles Uhl, Sr.

3.(b) Social Security Number: 218-26-4280

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Gertrude A. Uhl
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): September 3, 1876

8. AGE:

Years	Months	Days	If less than one day
70	6	10	..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Commission Merchant
11. Industry or business: Self

FATHER
12. Name: Louis C. Uhl
13. Birthplace: Germany

MOTHER
14. Maiden name: Lizzie Steiner
15. Birthplace: Maryland

16. Informant: Louis C. Uhl Jr.
Address 4205 Fordham Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-17-47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland
18. Funeral director: George L. Schwab
Address 2101 Frederick Avenue

19. Mch 14 1947 (Date rec'd by registrar) E. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1947 to March 13 1947 and that I last saw h-- alive on March 13 1947

Immediate cause of death	DURATION
Coronary Thrombosis	10 d.
Due to: Coronary Sclerosis and Myocardial Insufficiency	2 y.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Wilson K. Tallman M.D. M.D. or other
Address Catonsville 6-28, Md. Date signed 3-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

02604

CERTIFICATE OF DEATH

Reg. Diat. No. 330

1. PLACE OF DEATH:
County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Arthur Holmes Uhler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Abbie Uhler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1880

8. AGE: Years	Months	Days	If less than one day
66	3	4	..... hrs. ..... min.

9. Birthplace Reisterstown Balto. Co.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Philmore Uhler
13. Birthplace Md.

MOTHER
14. Maiden name Maggie B. Brown
15. Birthplace Md.

16. Informant Abbie Uhler
Address Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1947 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Balto. Co.
18. Funeral director J. F. Eline & Sons
Address Reisterstown, Md.

19. 3-29- 19 47 (Date rec'd by registrar) Dary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 19 47, at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1 19 40, to 3-27 19 47 and that I last saw him alive on 3-26 19 47.

Immediate cause of death	DURATION
Cerebral Vascular Accident	4 da
Due to	
Due to	
Other conditions Cerebral Hemorrhage	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. D. Eagles, M. D.
M. D. or other
Address Reisterstown, Md. Date signed 3-29-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

★ 02606

Reg. Dist. No. 572.0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo
Hospital, institution, or street address where death occurred: Hillside Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Hillside Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Matthew Emsley Unsworth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Elizabeth Bancroft Unsworth
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Sept 12, 1906

8. AGE: Years: 40 | Months: 6 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Vineland, New Jersey (Town, county, and state)
10. Usual occupation: Technical Engineer
11. Industry or business: Electronics
FATHER 12. Name: Joseph Unsworth
13. Birthplace: New Jersey
MOTHER 14. Maiden name: Grace Lewis
15. Birthplace: New Jersey
16. Informant: Mrs. M. E. Unsworth
Address: Cockeysville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 (month) 22 (day) 47 (year)
Cemetery or crematory: Seabrook
Location: Vineland, New Jersey
18. Funeral director: Judson M. Brooks
Address: Sparks, Md
19. 3-19-47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

1

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18, 1947, at 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary occlusion	3/18/47
sudden	
Due to: Chronic heart disease, vascular	1947
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Bolivia Hudson M.D. DME. M. D. or other
Address: Towson 4 Md Date signed: 3/18/47

1-35

02607

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

Reg. Diat. No. 13751

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural near White Hall.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Baltimore.

City or town: Rural near White Hall
(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Liberty.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Alvin Beecher Valentine.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Lily M. Valentine.

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): October 29, 1889.

8. AGE: Years	Months	Days	If less than one day
57	4	15	...hrs. ...min.

9. Birthplace: Indiana.
(Town, county, and state)

10. Usual occupation: Farming.

11. Industry or business: Own farm.

FATHER — 12. Name: George Valentine.

FATHER — 13. Birthplace: Indiana.

MOTHER — 14. Maiden name: Elizabeth Gardner.

MOTHER — 15. Birthplace: Indiana.

16. Informant: Mrs. Lily M. Valentine.

Address: White Hall, Md. R.D.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 16, 1947 (month) (day) (year)

Cemetery or crematory: Forest Hill

Location: Chattanooga, Tenn.

18. Funeral director: Jacob Harkenstein.

Address: New Freedom, Pa.

19. Mar 15 1947 (Date rec'd by registrar) Edith L. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1947, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to March 14 1947

and that I last saw him alive on March 14 1947

Immediate cause of death	DURATION
Coronary Thrombosis	one day
Due to: Chronic Myocarditis	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Alan E. Smith M.D.
M. D. or other

Address: Stewartstown Pa. Date signed: Mar 15, 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

2-25

2-350-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02608 (107) Reg. Diat. No. 301

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs. 11 mths. 5 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 11 yrs. 11 mths. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville 28, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Edmondson Ave. near Ingleside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: William Weaver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Emma J. Weaver
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): December 10, 1885

8. AGE: Years	Months	Days	If less than one day
61	2	21	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Dairy business
11. Industry or business: Self

FATHER
12. Name: ~~Samuel~~ Weaver (William)
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Hartman
15. Birthplace: Maryland

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md.
18. Funeral director: Flynn & Fleming
Address: 1426 Light St.

19. 3/4 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1947 at 9:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1935 to March 3, 1947 and that I last saw him alive on March 3, 1947

Immediate cause of death	DURATION
Bronchopneumonia, left base	12 hours
Due to:	
Due to:	
Other conditions: Prostatectomy	1944

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: --
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Spring Grove St. Hosp. Catonsville 28, Md. Date signed: 3-3-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

02609

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH
County: Balto. Co. Md.
City or town: Arnolia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address (if not in hospital): 812 Register a Convalescent Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. Co.
City or town: Arnolia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4613 York Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Margaret B. Weinberg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry Weinberg
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20 - 1888

8. AGE: Years	Months	Days	If less than one day
58	8		hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: Joseph Butt
13. Birthplace: Balto. Co. Md.
MOTHER
14. Maiden name: Mary Ann Lentzer
15. Birthplace: Balto. Co. Md.
16. Informant: Henry Weinberg
Address: 3718 Rusterbrook Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/19/47 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore Md.
18. Funeral director: John A. Hogan
Address: 4201 Freemont Ave.
19. 3/18 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 19 47 at 10.43 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 19 47 to Mar. 15 19 47 and that I last saw h ER alive on Mar. 15 19 47

Immediate cause of death	DURATION
Uraemia	
Due to: Ureteral Obstruction	
Due to: Carcinoma Cervix	5 1/2 yrs
Other conditions: Cerebral Angiospasm	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Grant & Galvin M.D.
M. D. or other
Address: 113 N. Monument St. Date signed: Mar. 17 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

02610

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Orpington Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles H. Weller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sallye R. Weller
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): May 27. 1870

8. AGE: Years 76 | Months 9 | Days 22. | If less than one day: hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Retired Tire Decorator

11. Industry or business:

FATHER
12. Name: Charles N. Weller
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Schuckhardt
15. Birthplace: Germany

16. Informant: Sallye R. Weller
Address: 604 Orpington Road.

17. Burial (Burial, cremation, or removal — which?) Date thereof: Mar. 24. 1947 (month) (day) (year)
Cemetery or crematory: Lorraine
Location: Woodlawn Md

18. Funeral director: Mrs. Wm. John Teufel & Son
Address: 5311 Edmondson Ave.

19. 3/28/47 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 21 1947, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardio Vascular Disease	
Other conditions: Sudden Death Ingving	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dr. M. Kieffer Asst Med Exam Balto Co.
M. D. or other
Address: 1010 Leeds ave Date signed: 3-21-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

02611

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2926 Putty Hill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Margaret M. Wiley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widowed

6.(b) Name of husband or wife: William R.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1889

8. AGE:

Years	Months	Days	If less than one day
58	1	11	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: Samuel M. Gore

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Lydia Cooper

15. Birthplace: Baltimore

16. Informant: Milton Wiley

Address: 2926 Putty Hill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Ave.

18. Funeral director: Clarence F. Hoffmann

Address: 1639 Broadway.

19. 3/14 19 47 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8 1946, to March 13 1947.

and that I last saw h.er alive on March 13, 1947.

Immediate cause of death	DURATION
Carcinoma of Sigmoid Colon	5 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clarence F. Hoffmann M.D. M. D. or other

Address: 1331 E. North Ave Date signed 3-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02612

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs., 11 mos., 9 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 11 yrs., 11 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 East Heath Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Christina Willershausen

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: George Willershausen

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Catherine Bange

MOTHER 15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Bulb 6 Lot

18. Funeral director: A. Raine Evans

Address: 1400 S. Charles St

19. 3/5/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 1947, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1935, to March 4, 1947, and that I last saw her alive on March 4, 1947.

Immediate cause of death	DURATION
Chronic myocardial insufficiency--indef.	
Due to Arteriosclerotic cardiovascular-renal disease	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 3-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9429)

02613

CERTIFICATE OF DEATH

Reg. Dist. No. 37 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Sparks.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 2 yrs 10 mos 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Sparks Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Alice Owens Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife: Frederick Wilson dec.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1. 1864.

8. AGE: Years	Months	Days	If less than one day
82	9	7	hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Retired School teacher
11. Industry or business

FATHER
12. Name: Samuel Mainster
13. Birthplace: Long Green, Md.

MOTHER
14. Maiden name: Josephine Turner
15. Birthplace: Scotland

16. Informant: Harry E. Parkhurst
Address: Iglehart Building, Baltimore

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/12/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18. Funeral director: H. W. Mears and Son
Address: 805 N. Calvert Street

19. March 8, 47 (Date rec'd by registrar) 19 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947, at 7A, M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1941 to 3/8 1947 and that I last saw her alive on 3/7 1947.

	DURATION
Immediate cause of death: Coronary Thrombosis	24 hrs.
Due to: Phlebitis of right leg.	2 days
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other
Address: Cockeysville Md Date signed 3/8/47

)-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02614

Reg. Dist. No. 4-20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 31 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 64 Shipway

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: PAUL WILSON

3.(b) Social Security Number: 174-05-1217

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Wilson

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 9-19-1896

8. AGE:

Years	Months	Days	If less than one day
50	5	26	....hrs. ....min.

9. Birthplace: Boston, Mass. (Town, county, and state)

10. Usual occupation: Supply Office, Vets. Adm.

11. Industry or business: Veterans Administration

FATHER 12. Name: Charles Wilson

13. Birthplace: Mass.

MOTHER 14. Maiden name: Margaret Fosnot

15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave.

19. March 17 19 47 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12, 1947, to March 15, 1947 and that I last saw him alive on March 15, 1947

	DURATION
Immediate cause of death: NARROWING OF ORIFICE OF LEFT CORONARY ARTERY WITH INFARCTION OF LEFT VENTRICLE	Unknown
Due to: Arteriosclerosis	
Due to:	
Other conditions: Arteriosclerosis of Aortic Valve with insufficiency, hypertrophy and dilatation of left Ventricle. (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: ....Date of op. ....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Robert Brett M.D. M. D. or other

Address: Fort Howard, Md. Date signed: 3-15-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (No a)

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home: Reisterstown, Md.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Margaret JoANNe WISE

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 29, 1945

8. AGE: Years	Months	Days	If less than one day
1	9	10	..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Raymond E. Wise
13. Birthplace Sparks, Md.

MOTHER
14. Maiden Name Vivien Flagle
15. Birthplace Baltimore, Md.

16 (a) Informant Raymond E. Wise
(b) Address Reisterstown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Asbury Cemetery
Location Reisterstown, Md

18 (a) Funeral director Um Berryman & Sons
(b) Address Reisterstown, Md.

19 (a) 3-10-47 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-1947, at 1-30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident probably ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Compression of lungs by massive accumulation of ~~Due to~~ milky fluid in both chest cavities, probably the ~~Other Conditions~~ result of rupture of the esophagus.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-9-47 at 10.30 a. M.
(b) Where did injury occur? Reisterstown Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fell from high chair

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 3/10/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

02616

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Parkton Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Parkton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Doyle J. Woomer
3.(b) Social Security Number: 206-01-3873

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: Sept. 14 - 1910
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 14, 1910

8. AGE: Years 36, Months 7, Days 17. If less than one day ... hrs. ... min.

9. Birthplace: Bellefonte Pa. (Town, county, and state)
10. Usual occupation: Contractor
11. Industry or business: Stone Mason

FATHER
12. Name: Lloyd Woomer
13. Birthplace: Bellefonte Pa.

MOTHER
14. Maiden name: Harriet Benner
15. Birthplace: Bellefonte

16. Informant: Marguerite Wilmen
Address: Parkton R.D.

17. Milesburg Center Co. Pa. Apr. 1, 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)
Via Motor Truck
Cemetery or crematory: Myers Chapel
Location: Milesburg, Center Co. Pa.

18. Funeral director: J. Jacob Hartenstein
Address: New Freedom Pa.

19. Apr 1 1947 (Date rec'd by registrar) Charles L. Fuller, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 31 1947, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... Dead on arrival
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: A. M. France, M. D. ~~or other~~
Address: Parkton, Md. Date signed: 3/31/47

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

02617 P

Reg. Diat. No. 381

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 E. Pennsylvania Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Richard C. Wright

3.(b) Social Security Number: 218-07-9230

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 30, 1878

8. AGE: Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Grocer
11. Industry or business
FATHER — 12. Name: Calvin D. Wright
13. Birthplace: Baltimore, Md.
MOTHER — 14. Maiden name: Mary Agnes Blaine
15. Birthplace: Baltimore, Md.
16. Informant: Mrs. Agnes Tucker
Address: 312 E. Pennsylvania Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 10, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.
18. Funeral director: Mrs. George A. Hallan
Address: 1631 Druid Hill Ave.
19. 3/10/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 6 1947, at 6 39 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 10 1947 to Mar. 6 1947 and that I last saw h[illegible] alive on Mar. 5 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	24 days
Due to: Hypertension	—
Due to: Arteriosclerosis	
Other conditions: Lobular Pneumonia	3 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. P. Hughes M.D.
M. D. or other
Address: 825 N. Fremont Ave. Date signed: 3/8/47

M — MARGIN RESERVED FOR BINDING — I — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — T — VS A15

02618

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 C 0

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Norris Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harrold Young

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1917

8. AGE: Years	Months	Days	If less than one day
29	11	14	..... hrs. ..... min.

9. Birthplace: Essex Co., Virginia
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business

FATHER
12. Name: Winston Young
13. Birthplace: Va.

MOTHER
14. Maiden name: Louise Rome
15. Birthplace: Va.

16. Informant: Winston Young
Address: 604 Peach Orchard Lane, Dundalk Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvery,

Location: Brooklyn, Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantly Ave., Baltimore, Md

19. 3/18/47 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

3/17/47 11:30 P.M.

20. DATE OF DEATH: March 17th 19 47, at 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..

and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Coronary Occlusion	2 hrs.
Due to (Acute Dilatation of Stomach)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: W. Bowers M.D. M. D. or Coroner

Address: Dundalk Md. Date signed 3/18/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1818 E. 02619

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or ~~town~~ Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 310 Westowne Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Westowne Road
(If rural, give LOCATION)
2.(a) If veteran, name war N

3.(a) FULL NAME Henry W Zeller

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Elizabeth K.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 13. 1866

8. AGE: Years 80 | Months 3 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Steel Metal Worker
11. Industry or business

FATHER
12. Name John F Zeller
13. Birthplace Germany

MOTHER
14. Maiden name Caroline Hafter
15. Birthplace Germany

16. Informant Henry E Carmine
Address 304 West Sweet Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/47 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md
18. Funeral director Wilson & Son
Address 1214 St Paul St

19. April 3 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, May 31 1947 and that I last saw h alive on May 3 1947

Immediate cause of death	DURATION
Cardio - Vascular - Renal disease	2 yrs.
Due to	
Due to	
Other conditions Chronic hypertrophy of prostate with Chronic Retention.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. P. Van Schuyver M.D. M. D. or other
Address 4818 Edmondson Ave Date signed 4/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15